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ABSTRACT

A four-phase project was undertaken to expand adult basic education (ABE) program outreach to meet the needs of the underserved, rurally isolated, older residents of south and southwest Iowa. The first phase of the project consisted of an advisory committee project review, a series of ABE staff interviews of senior citizens residing in the area, and a needs survey. In the second phase of the project, curriculum units were developed to help the area senior citizens to (1) build their self-confidence and self-respect, (2) improve their basic skills, (3) develop a better understanding of their role as citizens, and (4) become wiser consumers. Next, a day-long inservice session was held to prepare local ABE instructors to field test the project. Formative and summative assessments of the programs attested to its success. (Appendixes to this project report include maps of the project sites, the student and teacher handouts, an attitude-toward-aging scale, a project schedule, various recruitment and publicity materials, the pre- and posttests administered to the students, and a dissemination workshop agenda.) (MN)

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SENIOR ADULTS ON THE GO

A 310 Final Project Report

Fiscal Years 1984 and 1985

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July 1, 1985

CE 042 519

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A. Evidence of Need and Problem Statement

1. Introduction. There was a need for a new and innovative approaches to expand program outreach in order to effectively meet the underserved rurally isolated older residents of South/Southwest Iowa.

Recognizing this challenge, the College's Board of Directors, Administration and faculty adopted a five-year plan to guide the College in its effort to provide services to the residents of the area. Two of the long range goals that addressed the 310 Project proposal are as follows:

Goal 1.0 Increase accessibility of programs and services throughout the area and without regard to age, sex, social or economic class, racial or emotional handicap, or prior educational achievements.

Objectives

1.1 As a result of the planned activities designed to increase accessibilty of programs and services through the area, the College will observe the following outcomes.

(b) The College's faculty will learn, develop and implement new and innovative teaching methodologies within 25% of courses/programs offerd by the College by July 1, 1987.

(c) The College will investigate, research, and implement at least one innovation within its scheduling strategy by July 1, 1987.

Goal 2.0 To assess the educational needs of the service area, the College and its students for the purposes of determining the educational programs and services needed.

Objectives

1.1 To better assess the educational needs of the service area, the College will plan, develop and implement an annualized needs assessment program that takes into account student and industry employment needs beginning in the spring of 1983 and continuing through 1987.

The purpose of the proposal was to design, develop, and implement educational activities for the rural elderly of the area that would partially attain the above stated college goals.

2. Identitication of Target Population. The primary target group addressed in Senior Adults On The Go: ABE Curriculum Project were those older persons residing in the merged area.

From the general population, a core group of 600 to 700 golden agers living in eight area communities (see Appendix A for locations and names of focus communities) were identified as the project focus.

The secondary target group were those ABE teachers employed by the College. These teachers reside in close proximity of the sites. The training of these teachers provided an efficient delivery system. Each teacher served as the local recruiters and developed a delivery system most appropriate for their site.

The project area is located in the south-central/south-west portion of Iowa encompassing eight counties. The eight counties cover approximately 4,000 square miles and have a population of 75,382 persons according to the 1980 U.S. Census. The rural nature is characterized by small, scattered cities in the area, only ten had a 1980 population of over 1,000. Only three communities are considered urban. There are approximately 19 people per square mile throughout the area. (See Appendix B showing the area within the State of Iowa).

3. Assessment Procedures Used To Identify Needs. The College used a variety of assessment procedures to identify needs of the primary target population. These techniques included (1) Advisory committee project review, (2) ABE staff interview of senior adults, and (3) needs surveys. Other resources included (1) the 1980 U.S. Census data, (2) the 1976 Iowa ABE Target Population Study, (3) the 1978 Assessment of Community Mental Health Authority and the 1980 Low Income Individuals in Iowa School Districts and Counties report to the Department of Public Instruction.

The results of these various techniques were used to determine the needs addressed within the proposal. A continuous assessment plan was included as part of the project.

4. Problem Statement. The College had identified four need areas and had developed the following problem statements to clearly define the scope of work proposed.

The identified needs of the area rural/farm senior adult (in accordance with scope of "Philosophy of Adult Basic Education for Iowa") are expressed below.

(a) Need 1. Building self-confidence and self-respect in role of the older person.

(b) Need 2. Providing the opportunity for improving basic skills.

(c) Need 3. Helping the participants to have a better understanding of his or her role as a citizen.

(d) Need 4. Assisting the participant in becoming a wiser consumer.

The problem statements dealing with Senior Adults On The Go were as follows.

(a) Problem 1. There was a need for the development of curriculum units for use by ABE instructors that met the unique socio-economic needs of the rural/farm elderly.

(b) Problem 2. There was a need to train ABE teachers in the use of the developed curriculum units.

(c) Problem 3. There was a need to develop a cooperative linkage between the College and the senior adults to enhance adult education outreach programs to include the rural/farm elderly of Southwest Iowa.

(d) Problem 4. There was a need to continuously assess the educational needs of the target population.

5. Supportive Data. The supportive data for the College's proposal for a rural/farm elderly ABE curriculum project has been compiled from a variety of sources: state-wide research studies, local surveys and local participation committees.

A statistical profile of the area's elderly is shown below in Table 1. The area has the highest incidence of over 55 population in the State of Iowa. Over 30 percent of the population of the area is 55 and over according to the 1980 census, 32 percent greater than the state average.

TABLE 1
Percent of Population Over 55*
By County, By Area, By State

Unit	Total Population	Population over 55	% over 55
Adair	9,509	2,977	32.3
Adams	5,731	1,758	30.7
Clarke	8,612	2,352	27.3
Decatur	9,794	2,744	28.0
Montgomery	13,413	4,107	30.6
Ringgold	6,112	2,037	33.3
Taylor	8,353	2,822	33.8
Union	13,858	3,954	28.5
Area XIV	75,382	22,751	30.2
Iowa	2,913,808	666,505	22.9

*Source: 1980 U. S. Census.

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The rural/farm nature of the area is dramatically revealed in Table 2 below. Area XIV is 72 percent more rural than the state of Iowa is a whole. Four area counties are considered 100 percent rural and all remaining counties are more rural than the state average.

TABLE 2
Percent of Population Designated Rural*
By County, By Area, By State

Unit	Total Population	Rural Population	% Rural
Adair	9,509	9,509	100.0
Adams	5,731	5,731	100.0
Clarke	8,612	4,862	56.5
Decatur	9,794	7,089	72.4
Montgomery	13,413	6,603	49.2
Ringgold	6,112	6,112	100.0
Taylor	8,353	8,353	100.0
Union	13,858	5,429	39.2
Area XIV	75,382	53,688	71.2
Iowa	2,913,808	1,205,576	41.4

*Source: 1980 U. S. Census Report

The percent of low income farm individuals is two and one-half times the state average. (See Table 3). There are twice as many aged Iowans receiving public assistance in the area in comparison to the rest of the state. These social factors contribute to the need for a curriculum development project on golden agers in the area.

TABLE 3
Comparison of Percent of Population
Disadvantaged in the Merged Area Within
State of Iowa*

Disadvantagement	Percent of Population	
	Merged Area	State of Iowa
Public Assistance Groups		
ADC	2.89	3.21
Aged	1.05	0.50
Blind	0.05	0.03
Disabled	0.07	0.53
TOTAL	4.69	4.27
Low Income Groups		
Farm	5.50	2.00
Non-Farm	11.20	9.30
TOTAL	16.70	11.30

*Data adapted from "Low Income Individuals in Iowa School Districts and Counties" a report to State of Iowa Department of Public Instruction, 1980.

The 1980 U. S. Census provides additional evidence of the poverty level of the elderly in Area XIV. The incidence of poverty among area residents over 65 is twice the state average (See Table 4 below).

TABLE 4
Percent Population Over 65
Designated Below Poverty*

Unit	Total Population	Below Poverty	% Below
Adair	9,509	294	3.1
Adams	5,731	217	3.8
Clarke	8,612	293	3.4
Decatur	9,794	396	4.0
Montgomery	13,413	257	1.9
Ringgold	6,112	298	4.9
Taylor	8,353	262	3.1
Union	13,858	419	3.0
Area XIV	75,382	2,436	3.2
Iowa	2,913,808	47,083	1.6

*Source: 1980 U. S. Census

A pervasive problem with the rural/farm elderly of Area XIV is the low percent of formal education completion. A study conducted by Western Iowa Tech Community College for the Iowa Department of Public Instruction shows that those persons over 60 in Area XIV have a low percent of high school completion. Table 5 reveals that extent of educational disadvantagement that exists amoung the rural/farm elderly of Area XIV.

TABLE 5
Years of School Completed
By Age Cohorts For Age
60 and Over For FY 1976 in Area XIV

Grades Completed	White Females	White Males	Non-Whites Both Sexes
0 - 8	42%	61%	55%
0 - 11	16%	15%	40%
12	26%	16%	---
13+	15%	9%	---
Total	99%	101%	100%
Number	9841	7834	31

Additional supportive data was gathered during a survey of the rural/farm elderly served at congregate meal sites by the

Area Agency on Aging (AAA). The data showed that career education needs for this population group was very low. Of the 308 respondents to the questionnaire less than 3 percent responded positively to the need for additional career training.

A survey of the College's ABE Participatory Planning Committee was conducted by the College's ABE Coordinator. The survey data showed the local Participatory Planning Committee positively endorsed the concept of educational presentations for older Iowans.

The committee was in agreement that reaching these adults would help to develop self-worth, better communication and coping skills, basic skills and a better understanding of the participants' roles as citizens.

B. Goals and Objectives

1. Project Goals. The educational goals for the College's proposed SAOG: ABE Curriculum Development for Rural/Farm Elderly are presented below.

Goal 1.0 The developed ABE curriculum for rural/farm elderly will:

(a) Enhance the older persons self-confidence and self respect,

(b) Provide an opportunity for improving the elderly person's basic skills,

(c) Increase understanding of the older person's role as a citizen, and

(d) Enhance the older person's understanding of the role of a wise consumer.

Goal 2.0 A secondary goal of the SAOG project is to encourage and enhance inter-agency and inter-departmental (i.e. Adult and Continuing Education Division) cooperation.

2. Overall Objective. As a result of participation in the College's ABE curriculum project, the rural/farm elderly clients of the SAOG project will enhance their understanding of their role as an older citizen, increase their self-concept and consumer involvement.

Objectivie 1.0 The project director will prepare a survey instrument to ascertain participant curriculum interest areas.

Objective 2.0 The project director will coordinate project consultant's curriculum development of four ABE curriculum units for rural/farm elderly.

Objective 3.0 The project director will conduct a workshop for the College's ABE instructors for the purpose of:

(a) Learning curriculum content of the four ABE elderly units,

(b) Learning teaching methodologies to be used in interaction with rural/farm elderly, and

(c) Working as local coordinator.

Objective 4.0 The College's ABE instructors will provide ABE rural/farm elderly curriculum instruction to the participants.

Objective 5.0 The project director and external evaluator will assess the project's effectiveness and feasibility through formative and summative evaluation procedures.

Objective 6.0 The project director will prepare and disseminate the final report and all other materials required by the Department of Public Instruction.

C. Operational Plan. The first year of the College's rural/farm elderly curriculum project was accomplished in four phases.

Phase One: Assessment and Research

Phase Two: ABE Curriculum Development

Phase Three: Field Testing and ABE Instructor Training

Phase Four: Final Reporting and Dissemination

A set of milestones was used. The College and the project director monitored progress of the rural/farm elderly curriculum and training project. The milestones for each phase of the grant period were:

Phase One (July 1 to September 30, 1983)

1. ABE Coordinator served as Project Director.

2. Project Director, with local ABE instructor's assistance, assessed participants' interests through local surveys (See Appendix C).

A survey instrument was prepared by the project director with assistance from the Creston SAOG coordinator. This survey was distributed to a total of 200 senior adults from the three communities, 131 surveys were returned for a 66% return. Senior adults did express an interest in ABE programs. Through the personal contacts by the local coordinators, senior adults expressed the need for special programs. They were not interested in attending existing ABE classes. They felt out of place, but if they could have classes just for them in a familiar setting they would participate. This was the approach taken.

3. The Project Director contracted with ABE curriculum developers to construct rural/farm elderly ABE curriculum units.

Four topic areas were chosen as a result of the interest survey. The four areas included foreign travel, Iowa history, music from days gone by, and wills and trusts. A fifth program was added, not as a result of the survey but simply chosen to see if the senior adults would participate in a program not of their own choosing.

4. The College's ABE instructors were informed of project goals and objectives. Ideas were solicited.

5. Contracted curriculum developers researched availability of prepared materials.

6. Formative and summative assessment begun.

Phase Two (October 1 to December 31, 1983)

1. The five curriculum developers each researched, planned, developed, and prepared one ABE curriculum unit based upon the identified participant interests using commercial, as well as, teacher made materials.

Phase Three (January 1 to May 30, 1984)

1. The College's ABE Coordinator conducted an inservice designed to prepare the local instructors for field testing the units and to sensitize the instructors to the unique learning problems of older Iowans.

A day long workshop was held for writers and the three local coordinators. The workshop was presented by an Iowa State Extension Specialist, the ABE Coordinator, and Dean of Adult Education. The ISU Specialist presented teaching methodologies to be used with the senior adults. The Dean presented how to construct a unit. The ABE Coordinator covered background of project, expectations of writers and curriculum construction. The inservice was held in January (See Appendix D).

2. The field testing activities were conducted by the ABE instructors. Each instructor taught sixteen curriculum lessons, or four lessons for each of four units. The field testing occurred at 3 sites with an anticipated audience of 15 to 20 at each site.

However, the programs were very well attended for the pilot project. Hours and attendance were:

ATTENDANCE	COMMUNITY	UNIT	CONTACT HOUR
58	Red Oak	Music From Days Gone By	124
13	Creston	Computer	39
71	Creston	Music From Days Gone By	132
30	Creston	Exercise	30
27	Creston	Cooking for 1 or 2	27
20	Red Oak	Computer	80
41	Red Oak	Iowa Depression	120
22	Red Oak	Foreign Travel	40
14	Lamoni	Iowa Depression	32
5	Lamoni	Computer	10
11	Lamoni	Wills, Trusts	22
312			656

ABE instructors presented the programs and they had to be flexible. Although the units were designed for four hours of instruction, two of the programs were shortened due to poor attendance.

In Lamoni, the seniors become so involved that the computer and wills classes were extended for an extra session.

3. On-site evaluation of the field testing was conducted by the project director and ABE instructors.

4. Formative ans summative assessments were continued.

The project director continually evaluated the progress of the project. The Department of Public Instruction consultant was continually informed of progress.

Phase Four (June 1 to June 30, 1984

1. The project director prepared and disseminated the final report for the first year of the project.

2. Final reports submitted to Iowa Department of Public Instruction.

Second Year

The second year of the project was accomplished in four phases.

Phase One: Revising of Units

Phase Two: Instructor Training

Phase Three: Implementation

Phase Four: Evaluation and Final Reporting

Phase One (July 1 to December 30, 1984)

1. Units were revised.

2. Finished copies were printed.

Phase Two (February 1985)

1. A new project director was designated.

2. A day long workshop was presented by the ABE Coordinator and project director. Topics presented were background of project, teaching methodologies, characteristics of senior adults, recruitment methods, curriculum construction, coordination of classes and schedules (See Appendix E).

Phase Three (February 1 to May 30, 1985)

1. Sites were selected.

The sites varied in the five communities. A church, a bank, a neighborhood center, a community center, and a senior housing site community room were utilized for instructional purposes.

When selecting sites, consideration was given to accessiblitity, interior lighting, temperature control, roominess, and comfortable seating for the participants.

2. Schedules were coordinated.

Because of teacher preferences and site availability, each of the five subjects were presented in two 2-hour classes at each locations. The classes were presented in the same sequence at each site, with staggered beginning dates (See Appendix F).

3. Recruitment began by the instructors.

Each instructor was paid for 15 hours of recruitment. The types of recruitment utilized varied with each instructor. Some of the recruitment techniques used were:

1) visitation to club/organization meetings
2) one-on-one recruitment in businesses
3) personal phone calls
4) visitation with congregate meal site participants
5) door-to-door recruitment
6) newspaper advertisements
7) posters/signs in local businesses
8) visits to nursing homes
9) church meetings and bulletins

Flyers were printed by the college for distribution. They were handed out by the instructors when contact with perspective students was made (See Appendix G).

Diaries were kept by each of the instructors, documenting their use of the recruitment time. There diaries have been summarized and they indicate the face-to-face type of recruitment is the most successful (See Appendix H).

Each instructor was given $50 for advertising. The forms of advertising used were newspapers, posters, cable TV, radio announcements and the local shoppers. The newspaper ad seemed to be most effective; however, not as effective as the personal contact form of recruitment (See Appendix I).

It's obvious - to make a senior adult program successful, recruitment is essential. So often those who live close-in to the class site participated. Those residing in the country were more difficult to reach.

Very few were interested in "school" as they deemed the old traditional classroom. But once they understood what the program was about, they were more interested.

4. Actual implementation of units:

Attendance Duplicated	Attendance Unduplicated	Community	Unit	Contact Hours
17	17	Corning	Music	68
3	1	Corning	Iowa-Depression Years	18
0	0	Corning	Foreign Travel	0
6	6	Corning	Computer	24
13	8	Corning	Wills	52
27	27	Greenfield	Music	108
10	2	Greenfield	Iowa-Depression Years	40
15	10	Greenfield	Foreign Travel	60
4	1	Greenfield	Computer	16
3	1	Greenfield	Wills	6
51	51	Mt. Ayr	Music	204
17	4	Mt. Ayr	Iowa-Depression Years	68
11	1	Mt. Ayr	Foreign Travel	44
15	4	Mt. Ayr	Computer	60
23	6	Mt. Ayr	Wills	92
19	19	Leon	Music	76
13	7	Leon	Iowa-Depression Years	52
6	0	Leon	Foreign Travel	24
6	1	Leon	Computer	24
10	3	Leon	Wills	40
12	8	Bedford	Music	48
2	2	Bedford	Iowa-Depression Years	8
0	0	Bedford	Foreign Travel	0
4	3	Bedford	Computer	16
7	5	Bedford	Wills	28
294	187			1,176

Phase Four (May 15 to June 30, 1985)

1. Each instructor summarized her suggestions and experiences. Flexibility is the key. Although the units were well-prepared, each instructor had to adapt information to each specific group of adults. Each unit provides a wealth of information - much more than four hours worth.

2. Two of the units will need to be updated on a regular basis. These are "Wills, Trusts and Estates" and "Foreign Travel."

3. Each instructor must maintain control of the senior adult class. Beware of letting the music unit become a sing-a-long!

Afternoon sessions were preferred.

4. Both pre and post assessments were administered. The majority of senior adults were not receptive to completing pre-assessments or evaluations for the classes (See Appendix J).

5. The ABE Coordinator and project coordinator continually evaluated the project. Both felt the project was a success and hope to continue the project into a third year. This may be difficult because the 310 funding will end.

6. The project was disseminated to the ABE Coordinators in Iowa through use of the telenetwork system and a videotape of four SWCC presenters. An agenda and invitation to participate was extended to each of the fifteen ABE coordinators and their instructors. A half day workshop was conducted in May 1985. Each area school has received copies of the units and the support materials for each unit.

The combination of videotape and telenetwork for the presentation was a new venture in Iowa. the challenge came in synchronizing the two media forms (See Appendix J).

The workshop proved very successful. An evaluation of the workshop is enclosed (See Appendix K).

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MAP OF AREA CLASS SITES

APPENDIX A

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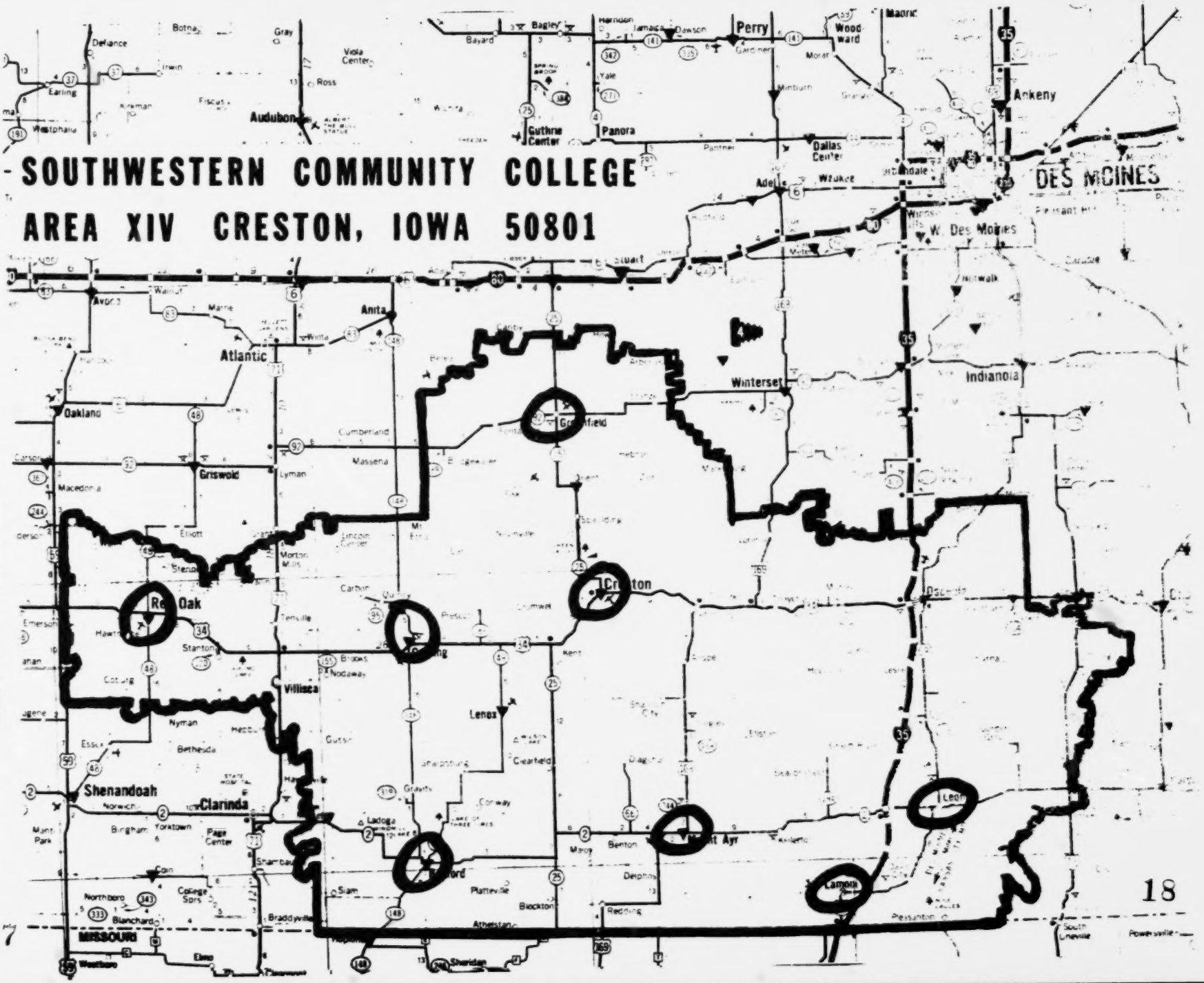

MAP OF AREA IN STATE

APPENDIX B

Goal 12.0 Continually assess the success of the College in accomplishing its mission and fulfilling its goals.

A complete statement of the college's mission and long-range goals may be found in Attachment A.

Socio-Economic Disadvantagement

Merged Area XIV is an eight plus parts of five county area in south-southwest Iowa. The counties are Adair, Adams, Clarke, Decatur, Ringgold, Montgomery, Taylor, and Union (see map 1 below). The total land area of the counties served is 3,845 square miles. The rural/farm nature of the area is characterized by small scattered communities and low population density.

AREA XIV MAP: 1

The Area is one of the least densely populated in Iowa. The 1980 census enumerates the total population at 75,382 persons.

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II. PROPOSAL NARRATIVE

1. Need

College Mission

The need for Adult Basic Education services in Merged Area XIV is first expressed in the College's mission statement and long-range goals. The mission statement includes, ". . . the College serves the citizens of Merged Area XIV while offering its programs to any student seeking a quality education. . . . providing growth and enrichment for individual needs."

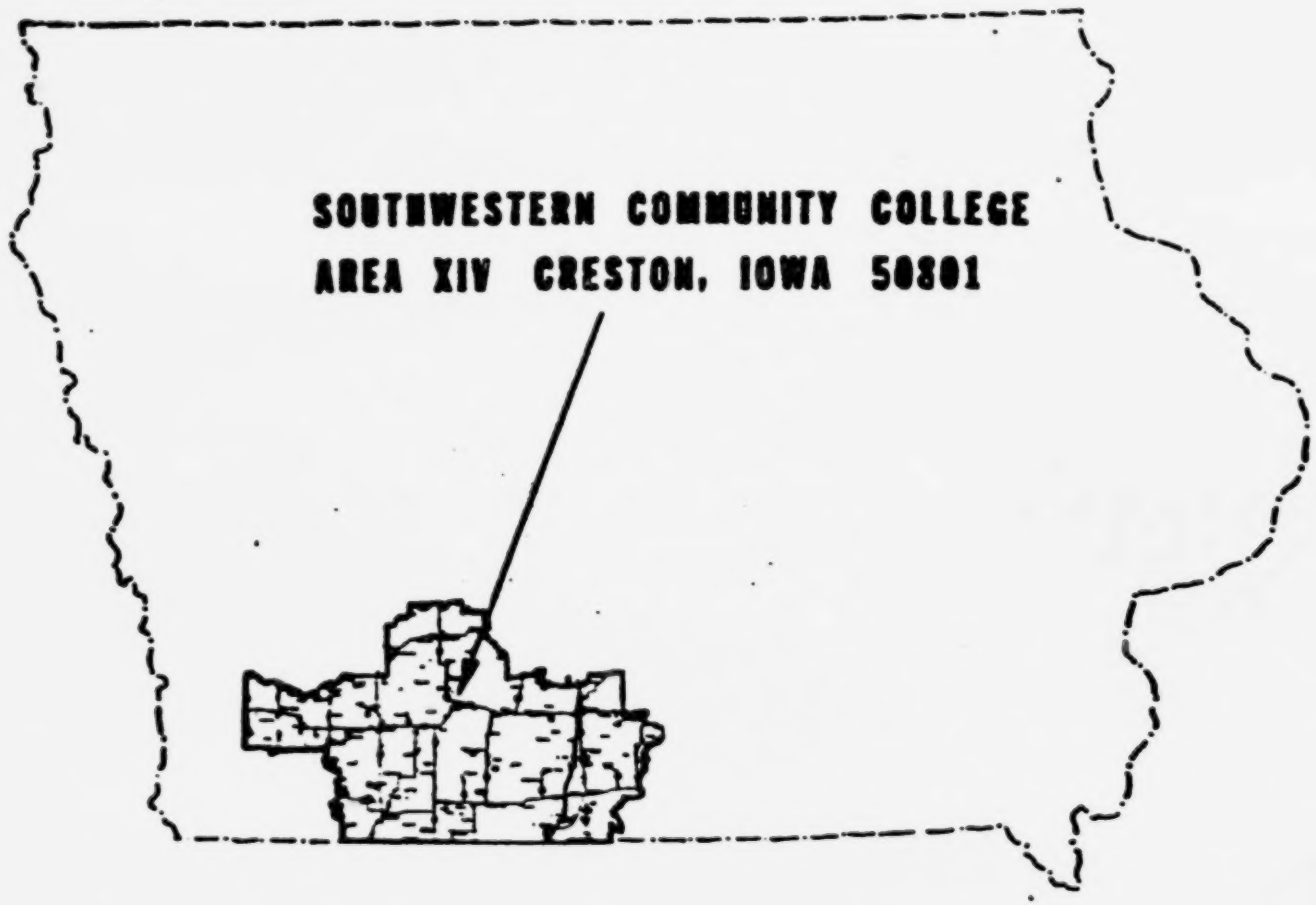
Long-range college goal statements of the college that address ABE service needs are as follows:

Goal 1.0 Increase accessibility of programs and services throughout Area XIV and without regard to age, sex, social or economic handicap, or prior educational achievements.

Goal 5.0 Intensify efforts to enhance the welfare, dignity and success of students.

Goal 7.0 Have available adequate funds to support College operations, programs and services.

Goal 11.0 Continue to provide programming for non-traditional target populations including under-educated, handicapped, economically disadvantaged, minorities, older adults and other identifiable groups of individuals.



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SURVEY

APPENDIX C

Dear Senior Adult,

Southwestern Community College will be presenting four informative programs at Acorn Acres in Red Oak next spring. In order to develop these programs and other programs specifically for your needs, we would like to know what is of interest to you. Please return this survey by November 30, 1983 to Ruth Dahl or Amy Halbert who are our local project coordinators.

This is not an obligation to attend the programs. It is simply an interest survey.

This list only suggests some possible topics. Please place a check in front of any programs of interest to you. Then underline the four topics of most interest to you. If you have additional suggestions, please include them.

___Heaven Can Wait (Death & Dying)
___Iowa History
___County History
___Exercise for the Senior Adult
___Coping With Your Adult Children & Their Children
___Relaxation - Games (History & Tips for Playing)
___Starting a Home-Based Business In Senior Years
___How to Write Letters that Get Answers
___Local Site Seeing
___How to Erase Bad Habits or Add Good Ones
___Foreign Travel
___Music From Days Gone By
___Autobiographies - Your Own Stories
___Architecture Styles In Southwest Iowa
___High Blood Pressure - How to Deal With It
___First Aid
___Cooking for 1 or 2
___Updating & Understanding Wills, Deeds & Estates
___Making Ends Meet - Living On a Fixed Income
___Art Appreciation
___Handling Stress
___How to Buy & Operate Pocket Calculators
___Microwave Use
___Smoke Detectors
___Energy Saving Devices & Energy Consciousness
___Other_____
_____
_____

___Special Diets
___Low Salt or Salt Free
___Soft
___Diabetes
___Weight Loss
___Understanding Yourself
___Insurance
___Disability
___Cancer
___Health
___Life
___Nursing Home
___Insurance Fraud
___Where to go for Help - Understanding Agencies & Programs
___Understanding Utility Costs
___The Many Aspects of Fraud
___Generic Drugs
___Creative Use of Leisure
___Consumer Education for Senior Adults
___Creative Writing
___Nutrition & Health
___Reading For Fun
___Appreciating Music
___Human Body
___Math Mania
___Typing Brush Up
___Being Able to Enjoy One Another
___Month to Month Bookkeeping
___Getting to Know All Those in the Housing Unit
___Communicating With One Another
___Developing Friendships
___Physical Therapy
___Cooking For Heart Patients
___Adapting Homes for Handicapped

Programs should be offered ___Morning ___Afternoon.

Optional signature_____

WORKSHOP HANDOUTS

APPENDIX D

Characteristics of Elderly Learners

Penny Ralston
Assistant Professor
Department of Home Economics Education
Iowa State University
Ames, IA 50011

Handout for presentation at Nutrition Education and the Elderly Workshop, Ames, Iowa, October 27, 1981.

Instructional Strategies for Facilitating Older Adult Learning[1]

Areas Related to Instruction	Strategy
*Climate	1. Establish supportive non-threatening climate 2. Encourage learner to take educated guesses
*Presentation of information	
-Mode of presenting information	1. Use auditory mode of presentation when presenting discrete bits of information to be used immediately 2. Use visual mode when presenting textual material to capitalize on opportunity for review during reading
-Rate of presentation	1. Present new information at a fairly slow rate 2. Let adult learner proceed at his/her own rate whenever feasible 3. Provide adult learner with ample time to respond to questions 4. Present a limited amount of material in any single presentation
-Organization of information	1. Present information in a highly organized manner 2. Use topical outlines or headings so that adult learners get a "handle" on material 3. Omit irrelevant information that might be confusing 4. Help adult learners develop retrieval plans
-Meaningfulness of information	1. Select information that is meaningful to adult learner 2. Assess "where learners are" to insure information is presented at appropriate level 3. Use examples and illustrations that are concrete

[1] Adapted from Okun, M.A., Implications of Geropsychological Research for the Instruction of Older Adults. Adult Education, Vol. XXVII, No. 3, 1977, pp. 139-155.

Areas Related to Instruction	Strategy
-Introduction of new material	1. Help adult learners to sort out information that is inaccurate or that "competes" with new information 2. Organize instructional units so that potentially interfering materials are spaced far away from each other 3. Stress differences between concepts before similarities 4. Introduce a variety of techniques for solving problems
*Facilitation of learning process	1. Provide ample opportunity for adult learner to overlearn material before moving on to new material 2. Encourage the use of mediators and mnemonic devices 3. Take advantage of experience the adult learner possesses 4. Relate new information to what learner already knows 5. Provide feedback to adult learner

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TEACHING METHODS FOR OLDER ADULTS

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Adapted by

Irene Beavers
and
Marjory Doyle

RATE OF PRESENTATION OF INFORMATION:

1. GO SLOWER - PRESENT NEW INFORMATION AT A FAIRLY SLOWER RATE.

2. LIMIT MATERIAL - PRESENT A LIMITED AMOUNT OF MATERIAL IN ANY SINGLE PRESENTATION TO PREVENT SWAMPING EFFECTS.

3. ALLOW TIME FOR QUESTIONS - PROVIDE ADULT LEARNER WITH AMPLE TIME TO RESPOND TO QUESTIONS.

4. PROCEED AT LEARNER'S RATE - LET ADULT LEARNER PROCEED AT HIS/HER OWN RATE WHENEVER FEASIBLE.

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ORGANIZATION OF INFORMATION:

1. ORGANIZE ALL NEW INFORMATION - PRESENT NEW INFORMATION IN A HIGHLY ORGANIZED FASHION

2. USE SECTION HEADINGS, HANDOUTS, SUMMARIES - USE SECTION HEADINGS, HANDOUTS, SUMMARIES, ETC., SO THAT ADULT LEARNER CAN GET A "HANDLE" ON MATERIAL

3. AVOID IRRELEVANT MATERIAL - AVOID INTRODUCTION OF IRRELEVANT INFORMATION IN ORDER TO PREVENT CONFUSION

4. USE SIMPLE VISUAL DISPLAYS

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FEEDBACK:

1. PROVIDE VERBAL FEEDBACK - GIVE CORRECT RESPONSE AFTER EACH COMPONENT OF TASK IS COMPLETED.

2. MAKE NO ASSUMPTIONS ABOUT PERFORMANCE - POOR PERFORMANCE ON A COMPLEX TASK MAY NOT BE INDICATIVE OF LOW APTITUDE.

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INTRODUCTION OF NEW MATERIAL:

1. ELIMINATE INAPPROPRIATE RESPONSES - IDENTIFY AND ELIMINATE INAPPROPRIATE RESPONSES WHICH MAY "COMPETE" WITH APPROPRIATE RESPONSE.

2. STRESS DIFFERENCES BETWEEN CONCEPTS - STRESS DIFFERENCES, BEFORE EMPHASIZING SIMILARITIES.

3. ASSESS LEVEL OF ADULT LEARNERS - INTRODUCE NEW MATERIAL AT APPROPRIATE LEARNER LEVEL.

4. USE VARIETY OF TECHNIQUES - INTRODUCE A VARIETY OF TECHNIQUES FOR SOLVING PROBLEMS.

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DEGREE OF LEARNING:

1. PROVIDE OPPORTUNITY TO OVERLEARN - PROVIDE AMPLE OPPORTUNITY FOR ADULT LEARNER TO OVERLEARN MATERIAL BEFORE MOVING ON TO NEW MATERIAL.

2. REMOVE TIME CONSTRAINTS - REMOVE TIME CONSTRAINTS FROM INSTRUCTIONAL AND EVALUATION PROCESS.

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ENHANCE LEARNING AND PERFORMANCE:

1. USE ADULT LEARNER EXPERIENCES.

2. RELATE NEW INFORMATION TO WHAT LEARNER KNOWS.

3. MAXIMIZE OPPORTUNITY FOR POSITIVE TRANSFER - DEVELOP LEARNING SETS.

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TEACHING STRATEGIES:

1. SHOW ACTUAL EXAMPLES - DEMONSTRATE.

2. ENCOURAGE LEARNER TRANSFER.

3. PRESENT MEANINGFUL INFORMATION - PRESENT INFORMATION WHICH HAS MEANING FOR THE ADULT LEARNER.

4. USE CONCRETE EXAMPLES AND ILLUSTRATIONS.

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MODE OF PRESENTING INFORMATION:

1. USE AUDIO FOR IMMEDIATE USE - USE AUDITORY MODE OF PRESENTATION WHEN PRESENTING DISCRETE BITS OF INFORMATION TO BE USED IMMEDIATELY.

2. USE VISUALS FOR TEXT MATERIAL - USE VISUAL MODE WHEN PRESENTING TEXTUAL MATERIALS TO CAPITALIZE ON OPPORTUNITY FOR REVIEW DURING READING.

3. UTILIZE MODELS - UTILIZE MODELS TO FACILITATE STRATEGY DEVELOPMENT.

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CLIMATE:

1. ESTABLISH A SUPPORTIVE CLIMATE.

2. ENCOURAGE ADULT LEARNER TO TAKE EDUCATED GUESSES.

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National Institute on Aging

Age Page

Hearing and the Elderly

It is easy to take good hearing for granted. In the world of the hearing impaired, words in a conversation may be misunderstood, musical notes might be missed, and a ringing doorbell may go unanswered. Hearing impairment ranges from difficulty understanding words or hearing certain sounds to total deafness.

Because of fear, misinformation, or vanity, some people will not admit to themselves or anyone else that they have a hearing problem. It has been estimated, however, that approximately 30 percent of adults age 65 through 74 and about 50 percent of those age 75 through 79 suffer some degree of hearing loss. In the United States alone, more than 10 million older people are hearing impaired.

If ignored and untreated, hearing problems can grow worse, hindering communication with others, limiting social activities, and reducing constructive use of leisure time. People with hearing impairments often withdraw socially to avoid the frustration and embarrassment of not being able to understand what is being said. In addition, hearing-impaired people may become suspicious of relatives and friends who "mumble" or "don't speak up."

Hearing loss may cause an older hearing-impaired person to be wrongly labeled as "confused," "unresponsive," or "uncooperative." At times, the feelings of powerlessness and frustration experienced by elderly individuals trying to communicate with others result in depression and withdrawal.

While older people today are, in general, demanding greater satisfaction from life, those with hearing impairments often find the quality of their lives diminished. Fortunately, help is available, in the form of surgery, treatment with medicines, special training, a hearing aid, or an alternate listening device.

Some Common Signs of Hearing Impairment

- Words are difficult to understand.
- Such sounds as the dripping of a faucet or the high notes of a violin cannot be heard.
- A hissing or ringing background noise is heard continually.
- Another person's speech sounds slurred or mumbled.
- Television programs, concerts, and social gatherings are less enjoyable because much goes unheard.

Diagnosis of Hearing Problems

If you are having trouble hearing, see your doctor for treatment or referral to a hearing specialist. By ignoring the problem, you may be overlooking a serious medical condition. Hearing impairments may be caused by: exposure to excessively loud noises over a long period of time, viral infections, vascular incidents (such as heart conditions or stroke), head injuries, certain drugs, tumors, excessive ear wax, heredity, or age-related changes in the ear mechanisms. In view of the importance of good hearing, seeking medical help is certainly worthwhile.

In some cases, the diagnosis and treatment of a hearing problem may take place in the family doctor's office. More complicated cases may require the help of specialists known as *otologists* or *otolaryngologists*. These specialists are doctors of medicine or doctors of osteopathy with extensive training in ear problems. They will conduct a thorough examination, take a medical history, ask about hearing problems affecting other family members, and order any other necessary laboratory tests. Many times they will then refer the patient to an *audiologist*. Audiologists specialize in the identification, prevention, and management of hearing problems and in the rehabilitation of people with hearing loss. They do not prescribe drugs or perform surgery, but they can recommend and sometimes dispense hearing aids. To test hearing, the audiologist uses an audiometer, a device which electronically generates sounds of different pitches and loudness. The testing is painless and within a short time the degree of hearing impairment can be determined and a course of treatment recommended.

Types of Hearing Loss

Presbycusis (pronounced prez-bee-ku 'sis) is a common type of hearing loss in older people. Changes in the delicate workings of the inner ear lead to difficulties understanding speech, and possibly an intolerance for loud sounds, but not total deafness. Thus, "don't shout—I'm not deaf!" is frequently heard from elderly persons with this type of hearing impairment.

Every year after age 50 we lose some of our hearing ability. The decline is gradual and progressive so that by age 60 or 70 as many as 25 percent of the elderly are noticeably hearing impaired. Just as the graying of hair occurs at different rates, presbycusis develops differently from person to person.

Although presbycusis is usually attributed to aging, it does not affect [illegible] researchers view it as a disease. Environmental noise, certain drugs, improper diet, and genetic makeup may contribute to this disorder. Although the condition is permanent, there is much a person can do to function well despite the impairment.

Conduction deafness is another form of hearing loss sometimes experienced by the elderly. It involves blockage or impairment of the mechanical movement in the outer or middle ear so that sound waves are not able to travel properly through the ear. This may be caused by packed ear wax, extra fluid, abnormal bone growth in the ear, or infection. People with this problem often find that voices and other sounds seem muffled, but their own voices sound louder than normal. As a result, they often speak softly. Depending on the cause, flushing of the ear, medicines, or surgery will prove successful in most cases.

Central deafness is a third type of hearing loss that occurs in the elderly, although it is quite rare even in this age group. It is caused by damage to the nerve centers within the brain. Sound levels are not affected, but understanding of language usually is. The causes include extended illness with a high fever, lengthy exposure to loud noises, use of certain drugs, head injuries, vascular problems, or tumors. Central deafness cannot be treated medically or surgically, but for some, special training by an audiologist or speech therapist can be beneficial.

Treatment

Examination and test results from the family doctor, ear specialist, and/or audiologist will determine the most effective treatment for a specific hearing problem. In some cases, medical treatment such as flushing the ear canal to remove packed ear wax or surgery may restore some or all of hearing ability.

At other times, a hearing aid may be recommended. A hearing aid is a small device

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designed to amplify sounds. Although hearing aids are not recommended for all hearing difficulties, some persons can benefit from a properly used device. Before you can buy a hearing aid, you must either obtain a written statement from your doctor (stating that your hearing impairment has been medically evaluated and that you might benefit from a hearing aid) or sign a waiver stating that you do not desire a medical evaluation.

Should a hearing aid be the recommended form of treatment for you, there are several things you should know about buying one. As an informed consumer you should shop for a hearing aid just as for any other product. There are many models on the market, offering different kinds of help for different kinds of problems. Hearing tests can determine the nature of the hearing problem, but only you can judge the comfort, convenience, and quality of sound of an aid. Remember, too, that you are not only buying a product, but a set of services which include any necessary adjustments, counseling in the use of the aid, maintenance, and repairs throughout the warranty period. Before deciding where to buy your aid, consider the quality of service as well as the quality of the merchandise.

When buying a hearing aid keep in mind that the most expensive hearing aid may not be the best for you. You may find one that sells for less and offers you more satisfaction. Buy an aid with only those features you need. Also, be aware that the controls for many of the special features are tiny and may be difficult to adjust. Choose an aid you can operate easily. Many hearing aid dealers (usually called "dispensers") offer a free trial period of up to 30 days so that you may wear the aid before making a decision. It is a good idea to take advantage of the trial period since it often takes at least a month to become comfortable with a new hearing aid. Your dispenser should have the patience and skill to help you through the adjustment period.

At times, people with certain types of hearing impairments may need special training. One form, speech-reading, trains a person to receive visual clues from lip movements as well as facial expressions, body posture and gestures, and the environment. Auditory training may include hearing aid orientation, but it is also designed to help hearing-impaired persons identify their specific communication problems and to better handle them. Although neither speech-reading nor auditory training can improve damaged hearing, they can reduce the handicapping effects of hearing impairment by making the best use of the hearing ability that remains. If needed, counseling is also available so that hearing-impaired elderly are able to maintain a positive self-image while understanding their communication abilities and limitations.

Cost

Because hearing impairments have so many causes, it is important to be examined by your doctor as soon as you suspect a problem with your hearing. Too often, people with hearing problems fail to get medical attention until the condition is beyond help. Unfortunately, the high cost of hearing health care contributes to this neglect. Medicare will pay for the diagnosis and evaluation of hearing loss if requested by a physician, but it will often not pay for the means to correct it. In some states Medicaid covers some costs of a hearing aid. Before buying an aid you may want to contact one of the organizations listed on the back page. Many local chapters are able to provide information concerning Medicaid coverage of hearing aids.

If You Have Problems Hearing

- See your doctor to determine the cause of your hearing problem. Ask if you should see a specialist.
- Don't hesitate to ask people to repeat what they have just said.

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- Try to limit background noise (stereo, television, etc.).
- Don't hesitate to tell people that you have a hearing problem and what they can do to make communication easier.

If You Know Someone With a Hearing Problem

- Speak slightly louder than normal. However, shouting will not make the message any clearer, and may sometimes distort it. Speak at your normal rate, but not too rapidly. Do not overarticulate. This distorts the sounds of speech and makes use of visual clues more difficult.
- Speak to the person at a distance of 3 to 6 feet. Position yourself near good light so that your lip movements, facial expressions, and gestures may be seen clearly. Wait until you are visible to the hearing-impaired person before speaking. Avoid chewing, eating, or covering your mouth when speaking.
- Never speak directly into the person's ear. This prohibits the listener from making use of visual clues.
- If the listener does not understand what was said, rephrase the idea in short, simple sentences.
- Arrange living rooms or meeting rooms so that no one is more than 6 feet apart and all are completely visible. In meetings or group activities where there is a speaker presenting information, ask the speaker to use the public address system.
- Treat the hearing-impaired person with respect. Include the person in all discussions about him or her. This helps to alleviate the feelings of isolation common in hearing-impaired persons.

For Your Reference

If you would like further information about hearing problems you may contact the organizations listed below. Please be sure to state clearly what type information you would like to receive.

American Academy of Otolaryngologists (Head and Neck Surgery), Inc., 1101 Vermont Ave., N.W., Washington, DC 20005. The Academy is a professional society of medical doctors specializing in diseases of the ear and related areas. They can provide information on hearing and balance disorders.

American Speech-Language-Hearing Association, 10801 Rockville Pike, Dept. AP, Rockville, MD 20852 (or call 1-800-638-8255 for the National Association for Hearing and Speech Action). Either organization can answer questions or mail information on hearing aids or hearing loss and communication problems in the elderly. They can also provide a list of certified audiologists in each state.

Office of Scientific and Health Reports, National Institute of Neurological and Communicative Disorders and Stroke, Bldg. 31, Rm. 8A06, Bethesda, MD 20205. The Institute is the focal point within the Federal government for research on hearing loss and other communication disorders. Ask for the Institute's pamphlet *Hearing Loss: Hope Through Research.*

Self Help for Hard of Hearing People *(Shhh)*, 4848 Battery Lane, Dept. E, Bethesda, MD 20814. *Shhh* is a nationwide organization for the hard of hearing. There national office publishes a bimonthly journal reporting the experiences of those with hearing impairments as well as new developments in the field of hearing loss. A number of publications and reprints are available for the hard of hearing.

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National Institute on Aging

Age Page

Aging and Your Eyes

Poor eyesight is not inevitable with age. Some physical changes occur during the normal aging process that can cause a gradual decline in vision, but most older people maintain good eyesight into their 80's and beyond.

Older people generally need brighter light for such tasks as reading, cooking, or driving a car. In addition, incandescent light bulbs (regular household bulbs) are better than fluorescent lights (tubular overhead lights) for older eyes.

Certain eye disorders and diseases occur more frequently in old age, but a great deal can be done to prevent or correct these conditions. Here are some suggestions to help protect your eyes:

- ☐ Have regular health check-ups to detect such treatable diseases as high blood pressure and diabetes, both of which may cause eye problems.
- ☐ Have a complete eye examination every 2 or 3 years since many eye diseases have no early noticeable symptoms. The examination should include a vision (and glasses) evaluation, eye muscle check, check for glaucoma, and thorough internal and external eye health exams.
- ☐ Seek more frequent eye health care if you have diabetes or a family history of eye disease. Make arrangements for care immediately if you experience signs such as loss or dimness in vision, eye pain, excessive discharge from the eye, double vision, or redness or swelling of the eye or eyelid.

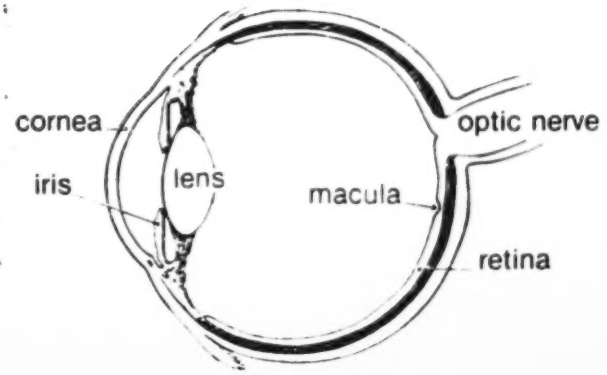
Common Eye Complaints

Presbyopia (prez-bee-oh′pe-uh)—a gradual decline in the ability to focus on close objects or to see small print—is common after the age of 40. People with this condition often hold reading materials at arm's length, and some may have headaches or "tired eyes" while reading or doing other close work. There is no known prevention for presbyopia, but the focusing problem can be easily compensated for with glasses or contact lenses.

Floaters are tiny spots or specks that float across the field of vision. Most people notice them in well-lighted rooms or outdoors on a bright day. Although floaters are normal and are usually harmless, they may be a warning of certain eye problems, especially if associated with light flashes. If you notice a sudden change in the type or number of spots or flashes, call your doctor.

Dry eyes occur when the tear glands produce too few tears. The result is itching, burning, or even reduced vision. An eye specialist can prescribe special eyedrop solutions ("artificial tears") to correct the problem.

Excessive tears may be a sign of increased sensitivity to light, wind, or temperature changes. In these cases, protective measures (such as sunglasses) may solve the problem. Tearing may also indicate more serious problems, such as an eye infection or a blocked tear duct, both of which can be treated and corrected.



Eye Diseases Common in the Elderly

Cataracts are cloudy or opaque areas in part or all of the transparent lens located inside the eye. Normally, the lens is clear and allows light to pass through. When a cataract forms, light cannot easily pass through the lens and this affects vision. Cataracts usually develop gradually, without pain, redness, or tearing in the eye. Some remain small and do not seriously affect vision. If a cataract becomes larger or denser, however, it can be surgically removed. Cataract surgery (in which the clouded lens is removed) is a safe procedure that is almost always successful. Cataract patients should discuss with their doctor the risks and benefits of this elective procedure. After surgery, vision is restored by using special eyeglasses or contact lenses or by having an intraocular lens implant (a plastic lens that is implanted in the eye during surgery).

Glaucoma occurs when there is too much fluid pressure in the eye, causing internal eye damage and gradually destroying vision. The underlying cause of glaucoma is often not known, but with early diagnosis and treatment it can usually be controlled and blindness prevented. Treatment consists of special eyedrops, oral medications, laser treatments, or in some cases surgery. Glaucoma seldom produces early symptoms and usually there is no pain from increased pressure. For these reasons, it is important for eye specialists to test for the disease during routine eye examinations in those over 35.

Retinal disorders are the leading cause of blindness in the United States. The retina is a thin lining on the back of the eye made up of nerves that receive visual images and pass them on to the brain. Retinal disorders include senile macular degeneration, diabetic retinopathy, and retinal detachment.

- ☐ Senile macular degeneration is a condition in which the macula (a specialized part of the retina responsible for sharp central and reading vision) loses its ability to function efficiently. The first signs may include blurring of reading matter, distortion or loss of central vision (for example, a dark spot in the center of the field of vision), and distortion in vertical lines. Early detection of macular degeneration is important since some cases may be treated successfully with laser treatments.

- ☐ Diabetic retinopathy, one of the possible complications of diabetes, occurs when small blood vessels that nourish the retina fail to do so properly. In the early stages of the condition, the blood vessels may leak fluid, which distorts vision. In the later stages, new vessels may grow and release blood into the center of the eye, resulting in serious loss of vision.

- ☐ Retinal detachment is a separation between the inner and outer layers of the retina. Detached retinas can usually be surgically re-attached with good or partial restoration of vision. New surgical and laser treatments are being used today with increasing success.

Low-Vision Aids

Many people with visual impairments can be helped by using low-vision aids. These are special devices that provide more power than regular eyeglasses. Low-vision aids include telescopic glasses, light-filtering lenses, and magnifying glasses, along with a variety of electronic devices. Some are designed to be

hand-held; others rest directly on reading material. Partially sighted individuals often notice surprising improvements with the use of these aids.

For More Information

The following organizations can send you more detailed information on eye care and eye disorders.

Office of Scientific Reporting
National Eye Institute
Bldg. 31, Rm. 6A32
Bethesda, MD 20205

This Institute, part of the Federal government's National Institutes of Health, conducts and supports research on eye disease and the visual system. They can send you a list of free brochures on eye disorders.

National Society to Prevent Blindness
79 Madison Ave.
New York, NY 10016

The Society has several free pamphlets on specific diseases affecting the eyes. To receive a free copy of their publication *The Aging Eye: Facts on Eye Care for Older Persons*, send them a self-addressed stamped envelope. They also have a *Home Eye Test for Adults* which is available for $1.00 (to cover the cost of postage and handling).

American Foundation for the Blind
15 West 16th St.
New York, NY 10011

This organization can send you a list of their free publications on vision.

Vision Foundation
2 Mt. Auburn St.
Watertown, MA 02172

The Foundation has published a *Vision Inventory List,* which includes information on special products and services for visually impaired people. There is no charge for the *List.*

Two professional societies that gather, study, and publish eye care information are:

American Optometric Association
Communications Division
243 North Lindbergh Blvd.
St. Louis, MO 63141

and

American Academy of Ophthalmology
1833 Fillmore
P.O. Box 7424
San Francisco, CA 94120

Write to them for free information on eye care for the elderly.

Publications

"Keeping an Eye on Glaucoma" is a reprint from the June 1979 issue of the *FDA Consumer.* It is available free from the Food and Drug Administration, 5600 Fishers Ln., Rockville, MD 20857. Please send your request on a postcard.

Cataracts: A Consumer's Guide to Choosing the Best Treatment is a large-print book available for $3.50 from the Public Citizen's Health Research Group, 2000 P St., N.W., Suite 708, Washington, D.C. 20036.

September 1983

Changes & Choices

Self-concept in the Later Years

Aging . . . as much as some of us would like to ignore it . . . is part of being alive. If we are not already, we will one day be in the later years of life. We'll experience the physical and emotional changes that come with the life stage of "old age," and we'll respond to it only as well as our self-concept allows. Understanding this, we can better adjust to our own aging and that of our family, friends and neighbors.

The Effects of Self-concept

Simply put, self-concept is how we see ourselves and how we feel about ourselves. The way we respond to change in our lives largely depends upon our self-concept. How we see ourselves can determine whether change is an unpleasant experience or a time for growth.

To be in touch with ourselves, with who we really are, helps us feel good. A strong self-concept makes it easier to accept change, use it, and grow with it.

The Many Changes as We Age

Change, of course, is nothing new. From the moment of birth we are constantly faced with change. As we grow older, however, the changes often seem to be bigger, and to come about more quickly, and sometimes seem to be more out of control.

As we enter the later years of life, our physical appearance changes. Our bodies don't seem to work quite as well as they used to. In addition, finances often become tighter. We begin to lose friends and loved ones. The way people treat us changes and the way we think about ourselves changes, too.

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So much of what we've been used to begins to fall away. And many of the changes are simply beyond our control. It's easy to wind up feeling down and frustrated. All these changes can be overwhelming, even frightening, but they don't have to be.

No matter what happens, regardless of the challenges we face, there is something we can hang on to and control.

Changes Mean Choices

This something to hang on to and control is how we choose to respond to the changes, the opportunities and the challenges of the lifelong process of aging. *With each change comes a choice.* We may not be able to do much about change, wrinkled skin or the loss of a spouse, for example, but we can have power and control over how we react to what happens. We control what we think and believe and how we feel—*if* we choose to.

A solid self-concept—one that is based on our "real self"—can go a long way toward helping us positively use this freedom of choice.

Limited Self Versus Real Self

As we grow older we often try to hold back the years with hair dyes, super-vitamins, wigs, affairs, cosmetics, youth-restoring lotions or face-lifts.

Too many of us have been programmed—almost brainwashed—into only identifying with what we might call our "limited self." The limited self is made up of our physical appearance, what we own, the kind of work we do, and so forth. These things seem important but are actually superficial.

We are almost constantly fed the message that who we are is our limited self. We hear it from TV, radio, well-meaning friends, advertisements, books and magazines. We are our bodies, our personalities, and what we do.

But this limited self is only part of our total or real self. *Our real self also includes our thoughts, our feelings, our intuitions, and that inner sense of calm and knowing—those parts of us that simply don't age.*

As one 90-year-old put it: "I want to cry out that the invisible part of me is not old . . . In aging we gain as well as lose. It's a time when our spiritual forces seem to expand. A life of the heart and of the mind takes over while our physical force ebbs away."

Unless we stay in touch with our real self—that peaceful inner part of us that doesn't age—our self-concept tends to remain weak and incomplete. Staying in

touch with our real self is the key to a full and strong self-concept. And a healthy self-concept is the key to successful aging.

Caring and Sharing

One special need many of us have as we age is simply to be listened to, *and to be listened to well.* We want to review and to talk about life, particularly the past, and our feelings concerning it. Listening and being listened to is a very important healing process. If done with sensitivity, this listening strengthens self-concept by helping us learn from the past, accept what is, plan for the future, and deal with our concerns and fears about passing on.

This sharing process is equally valuable to the elderly person reminiscing and to the one who has the opportunity of listening. Both receive; both give. Each is doing the other a favor. *It is this type of interdependence, and the good feelings created by it, that give our lives flow and meaning, and we must never underestimate its value.*

Thoughts for a Healthy Self-concept

- It's vital that each of us remember who we really are, that inner part of us that doesn't age, our real self.
- As we advance in years, it's important to remain as active and independent as reasonably possible.
- What we think determines how we feel. So it may be most helpful to watch our thoughts closely, particularly if we don't like how we're feeling.
- Regardless of who we are or what we're doing, staying tuned to our inner guidance is of great importance.
- And, of course, hanging on to our sense of humor makes the lifelong process of aging a lot more enjoyable.

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Resources for Nourishing Self-concept

Activities, People, Places

- **Volunteer Activities.** There may be a Retired Senior Volunteer Program (RSVP) in your area. Or, perhaps you're familiar with some interesting and rewarding volunteer possibilities in your community.
- **Family and Friends.** Though often overlooked, those near and dear are, in so many ways, often our best resources.
- **Senior Citizens Centers.** These exist in many different locations, and offer opportunities for making new friends while selecting from a variety of recreational and cultural activities.
- **Spiritual Assistance.** Ministers, priests, rabbis and other spiritual guides have a long history of being excellent sources of guidance and comfort.
- **Counseling Services.** Many Comprehensive Care Centers, for example, offer a wide variety of assistance and may provide help in better understanding the mental and emotional aspects of aging.
- **Telephone Services.** Telephone reassurance, listening and counseling services can be most helpful and are indeed as close as the nearest phone! Dial "Information" to see what's available in your area.
- **You.** Remember that you—young or old—are the best expert on you. Never shortchange your own common sense, and listen carefully to the promptings of your heart.

Prepared by Sam Quick, Extension Specialist in Family Life, and Belinda Adkins, journalism student, University of Kentucky

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Your Aging Parent

Understanding Changes in Thinking

Judith O. Hooper

Myths

There are probably more myths about the thinking of older people than there are about any other part of the life-span. If you have an aging parent, you may need to get rid of some of the myths you believe in before you can really understand and support that parent. For example, the phrase "you can't teach an old dog new tricks" expresses the myth that old people cannot learn. This myth hangs on, even though we see that old people living today have had to continually learn new things in order to live in a world which has changed so much since they were children.

Other myths are that all old people lose their memories, that they can't concentrate, that they can't understand complicated ideas and that they all become childish or senile in their thinking. Believing in these myths blocks our understanding of older people and causes us to think of the whole elderly population as if they were all the same. Most of us do not believe that *all* 40-year-old men are in excellent physical condition, or that *all* 33-year-old women have excellent memories or that *all* old people are the same in any way other than that they are no longer young.

Even "no longer young" has little meaning when you realize you know a person who is "old" at 55 and another who is "young" at 85. Recognizing that there are as many differences among old people as there are among young people is an important step toward understanding your aging parent. Next, you may want to get some facts about thinking in older adults.

Memory

There is a stereotypical joke where one elderly person says to another, "I understand that three things happen when people age. Their memory slips...and, well, I guess I forget the other two."

Despite a lot of research on memory in old people, it's still impossible to make hard, fast statements about it. Many older individuals never experience any memory problems at all. It seems that problems that do come up about remembering recent events have a lot to do with what was going on when the event occurred. That is, if an older person was paying close attention, interested and alert when something happened, it's likely to be remembered. On the other hand, if there was a lot of noise and confusion, or the older person was disinterested or paying attention to something else, the event is likely to be "forgotten."

Some researchers feel that if a recent event, a new acquaintance or a newly assigned telephone number are "forgotten," this really means that they weren't "learned" in the first place. You can help your aging parent remember (learn) important people, events, dates, places and so forth by making sure that the information is conveyed at a time when he or she is able to pay attention. Sometimes written reminders such as "take your pill at lunch time" or "Granddaughter Margaret's birthday is next Friday, December 12" will be helpful. While having to repeat information or provide "memory joggers" such as written notes may be a minor inconvenience, they can be very important in helping your parent retain a sense of independence and self-esteem.

In contrast to occasional forgetfulness about recent events, many older people seem to have remarkably clear memories of what happened long ago. Your mother may be able to describe in great detail her sister's wedding in 1910. Of course, since there is probably no one around to contradict her, it's difficult to know if such memories are *accurate*. The memories, accurate or not,

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are important because they recall important events in the aging person's life. They help that person review a whole lifetime and come to understanding and acceptance.

All of us go through this period of "life review" in our old age and that it is a normal part of aging. Such stories of long ago can be a rich resource for your family, a kind of oral history. Many aging individuals who are encouraged to remember and tell different events from earlier years enjoy this attention. Furthermore, there is evidence that occasionally being the center of attention in this way encourages the older person to be more "tuned in" to the events of today.

Learning

Recently, there has been a lot of talk about "the greying of the universities." Many colleges and universities, faced by smaller enrollments of young people, have begun to offer programs and classes for the elderly. Teachers in these classes have been enthusiastic about older learners, calling them interested, hard-working and intelligent. So—older people *can* learn. Not all older people will want to attend classes of course. In one study, older people reported that they learned new things every day, and that "living is learning." It's not necessary to be in school to be learning.

Perhaps your aging parent "can't learn" to use that fancy new stove because problems with hearing or vision get in the way. Perhaps he or she doesn't learn to use it because a younger person is always jumping in to "help." Maybe the old one was like a familiar friend and this new one is an intruder in the comfortable old kitchen. However, unless the older person is impaired by physical problems, new things and new ideas can be learned if there is enough time, patience and interest.

Stubbornness

Sometimes the children of old people complain that they are "stubborn" and "set in their ways." One hears of aging people who refuse to eat any green vegetables, or who insist on a big Sunday dinner, or who won't even discuss getting a new coat. One daughter remarked that "Mother is just the same as always, only more so." Certainly it seems to be true that most older persons don't change radically from the way they were in younger days. If your parent led a sedentary life earlier, he or she is not likely to become a jogger at age 70. Furthermore, people who are sedentary in youth may have more physical problems in old age and be forced to slow down even more. If your parent was outgoing and enthusiastic in younger years, chances are he or she will stay that way into old age, unless physical or emotional problems interfere.

Many older people find great comfort and support in things, people and places that are familiar and safe. They may hesitate to try new things for fear of making a mistake and looking "foolish." They may feel that certain habits, such as eating particular foods or having meals at particular times, have worked well until now and they are reluctant to try anything different in case it might cause problems.

Some older people will reject new ideas or new ways of doing things. Others seem to be more flexible and tolerant. Usually, both of these attitudes reflect similar attitudes that the individual had when younger. Children who can see their aging parents as the same, only older, rather than "one of those people who all think like that" can be more responsive and supportive during the later years.

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B3154 **YOUR AGING PARENT: UNDERSTANDING CHANGES IN THINKING**

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Growing Older: Sensory Changes

The efficiency of the sensory organs—vision, hearing, taste, smell, and touch—declines with age, but the age of onset and the rate of decline differ markedly among people. A sensory change can affect an older person in a number of ways. Changes can be made in the environment to ease a person's adjustment. This publication is addressed to those who care for the elderly—to explain the sensory changes older people encounter and to suggest what you can do to help.

What is it like to hear only a mumbling voice when someone speaks to you? How does it feel to have poor vision and no longer be able to read a newspaper or book? Why do some older people complain that food doesn't taste as good as it did when they were younger?

As people age, they experience changes in the sensitivity of their senses—vision, hearing, taste, smell, and touch. Although most older people function very well, such changes affect daily living. They may mean reduced mobility, increased dependence on others, inaccurate perception of the physical and social environment, reduced ability to communicate with others, frustration, difficulty in accomplishing tasks or not being able to do them at all, and not feeling good about oneself.

All of us should recognize that age-related sensory changes occur, in varying degrees, but if you have elderly family members or if you work with elderly persons it is especially important to understand the changes that are likely. If you lack knowledge and understanding, you may find yourself becoming frustrated easily, setting unrealistic expectations, or mistakenly labeling an older person—particularly the hearing impaired—as "senile," "confused," or "failing." Understanding these changes should increase your ability to provide positive support and to make changes in the environment that enhance the life of an older person. You probably will find yourself focusing more on what a person can do and less on what the individual cannot do.

What are the sensory changes commonly associated with growing older? What do these changes mean to the older adult and to you?

Changes in Sensory Organ Function

The sensory receptors become less efficient with age; therefore, older adults generally require higher levels of stimulation if their sensory receptors are to perform with a sharpness nearer that of younger people. Age, however, is not the only factor causing deterioration of the sensory organs. Disease and environmental factors are also important. Intense and prolonged noise affects hearing, smoking often reduces taste and smell sensitivity, and accidents may injure the eyes.

The changes in vision and hearing are particularly important because they affect not only the person's ability to function in the physical environment, but also may create isolation.

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Vision

The majority of older adults have good to adequate vision, but several aspects of vision do change with age. These changes include decreased visual acuity (sharpness), farsightedness, changes in color perception, decreased sensitivity to light, and decreased ability to adapt to glare.

Acuity

The most common change is a decrease in the ability of the eyes to see as clearly as when the person was younger. Visual acuity is generally at its maximum in the late teens, remains fairly constant until age 45-50, and then gradually declines. The Center for Health Statistics reports that by age 65, one-half of all people have a visual acuity of 20/70 (what can be seen at 20 feet, a person with perfect vision can see from 70 feet) or less, while fewer than 10 per cent of people 45 and younger have vision poorer than 20/70. In a survey by the National Optometric Association, one-third of those older than 65 reported that an inability to see well prevented them from doing things they wanted to do. More than half of all the severe visual impairments occur in people 65 and older.

Farsightedness (Presbyopia)

With age, the lens of the eye diminishes in its ability to see close objects. This change often becomes noticeable during the 40's and 50's, when it is not unusual to hear people say, "My arms must be growing shorter, I can't hold the paper far enough away to read it." Although bifocal lenses help, many older people still find it difficult to see small details, such as the hole of a needle, directions on medications, or numbers in a telephone directory.

Color perception

Several studies suggest that the lens of the eye yellows with age and filters out colors at the blue end of the light spectrum. As a result, an elderly person may not be able to discriminate between shades of blues and between blues, greens, and violets. For example, a 90-year-old nursing home resident could not see the blue flowers in a bouquet because the blue blended into the green leaves. An older person's outfit of different shades of blue may look poorly coordinated to a younger person, but to the older individual the colors may look the same. It is important not to interpret an inability to identify colors as a sign of confusion. Colors more easily distinguished by older adults are the yellows, oranges, and reds. For both pleasure and safety, these colors should be kept in mind when developing printed materials and painting or redecorating the environments of older adults.

Decreased sensitivity to light and increased sensitivity to glare

The eye decreases in its ability to adapt to changes in light level. An older person entering or leaving a darkened room usually requires more time to adjust to the changes in light levels than a younger person. Abrupt changes can be hazardous and cause falls or other accidents. Night lights in bedrooms and bathrooms and a consistent light level in both bedrooms and hallways help prevent accidents. Many older people prefer daylight driving because they experience momentary blindness and glare at night from lights of oncoming traffic and reflections from wet pavement.

Increasing age usually is accompanied by increasing dependence on good lighting to see effectively. Brightness of illumination usually must be increased 50 per cent at age 50, 100 per cent more at age 60, and another 33 per cent at age 80 to achieve the levels of visual sharpness, contrast, and reading speed present at age 20. In poor lighting, an older person may not see potential hazards or recognize familiar people.

When increasing light levels, distribute the light evenly and minimize glare. Older adults experience an exaggerated amount of glare from an intense light source. Glare that is hardly noticeable to a younger person may create difficulties for the older person. Shiny surfaces that produce glare need to be avoided in planning an environment.

Other age-related eye changes

Older people often experience cataracts, glaucoma, and macular degeneration. Cataracts are the most common disability. The lens of the eye changes from clear and transparent to cloudy and opaque resulting in distorted vision. It is said that everyone would develop cataracts eventually if they lived long enough. Surgery is nearly always successful in correcting visual losses caused by cataracts.

Glaucoma is less common, but is more serious than cataracts and can cause blindness. Glaucoma is caused by an abnormally high pressure in the eye, a condition created when the fluid that bathes and nourishes the eye cannot drain out of the eye and places pressure on the optic nerve. It is the "sneak thief of sight" because there are few early symptoms. If undiagnosed and untreated, glaucoma eventually can lead to blindness. Today early diagnosis and treatment can slow or prevent much of the vision loss. Preventive care is vital. Simple, painless checks for glaucoma should be performed annually on people past age 50. Persons with a family history of glaucoma should be particularly concerned with annual checkups. Glaucoma is usually treated easily and effectively with medication. Minor surgery to allow fluid drainage is sometimes necessary.

Nearly 30 per cent of the aged have some degree of macular degeneration, a condition that

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causes loss of central vision. Peripheral or side vision is not affected. The macula, an area 3/16 of an inch diameter in the retina, enables us to see fine details. When the macula is damaged, the person is able to get around by himself particularly in familiar surroundings, but often is unable to read, enjoy television, or identify people until they are close. Low-vision aids help a person to use remaining vision more effectively and efficiently. Treatment is largely concerned with prevention or slowing the progress of the disease by medical treatment.

Although most older people will have some loss of vision, many retain near-normal vision well into their seventies and eighties. However, persons with losses in vision may experience decreasing mobility, poor orientation, and frightening visual impressions that resemble hallucinations. Reading, watching television, and other pastimes may be reduced or eliminated. Older adults also generally feel more vulnerable to danger and crime when handicapped by vision and other sensory losses.

What can you do to help?

What can you do to help the visually impaired function more effectively in their environment? Techniques, in addition to those previously discussed, include the following:

- Use good contrast between the background and lettering of printed materials. Paper should have a dull finish and large lettering should be used.
- Obtain large-print books or "talking" books for the severely visual impaired who enjoy reading. Information about such books is available from state and local libraries.
- Use contrasting colors, for example, between doorways and walls, dishes and tablecloth, and the risers and flat surfaces of steps.
- Use coding schemes, for example, color or dots of glue at different points on oven and washing machine dials can make different dial settings easier to find and, consequently, enhance independent living.
- Simplify the visual field and avoid clutter, but don't change the location of objects without the person knowing about it.
- Give pre-warnings when approaching or moving the visually impaired. Otherwise, you may unintentionally frighten the person. Let the individual know what you are going to do. This gives advance information about actions and helps the person to feel more secure.
- Use touch to enhance communication. Holding or patting someone's hand can tell the person where you are and that you are listening and have not walked away while the individual is talking.
- When entering a new environment with a visually impaired person, explain the people present, and their location.
- When walking, let the visually impaired person take your arm just above the elbow. You will be walking a half step ahead. The person can better anticipate your movements and generally feels more secure than if you grab his arm.

Hearing

Hearing loss is potentially the most serious of the sensory impairments. Unlike poor vision, hearing loss rarely inspires sympathetic understanding. The seeing eye dog, thick glasses, and white cane all help us to identify the blind and visually impaired, but the hard-of-hearing and deaf are not as visible. In regard to her deafness, Helen Keller stated:

> "I am just as deaf as I am blind. The problems of deafness are deeper and more complex, if not more important than those of blindness. Deafness is a much worse misfortune. For it means the loss of the most vital stimulus—the sound of the voice that brings language, sets thoughts astir, and keeps us in the intellectual company of man —"

Hearing loss affects more people than any other chronic condition. From age 20 to 60, the rate of hearing impairments rises from 10 to 75 per 1,000 population. Between the ages of 60 and 80, the rate increases to 250/1,000 population. Approximately 30 to 50 per cent of all older people suffer a significant hearing loss that affects their communication and relationships with others. Older men usually have a greater hearing loss than older women. This is probably due to the fact that more men have worked in noisy jobs.

Hearing loss can lead to other problems. It can cause isolation, anxiety, and depression. Even a slight loss can be emotionally upsetting, particularly if it interferes with correctly understanding the television, family, and friends. Many people will withdraw from group situations when it becomes a chore to listen and to follow rapid topic changes in conversation. Travel by public transportation can be difficult, particularly if announcements over the intercoms are unclear. Furthermore, loss of hearing often occurs at a time when a person is adjusting to other age-related losses, including perhaps death of friends and loved ones. A hearing loss may complicate adjustment.

Types of hearing loss

The two general categories of hearing loss in the later years are conductive loss and sensory-neural loss. With conductive loss, sound waves are

not properly conducted to the inner ear. All sounds seem muffled. The cause may be an obstruction in the outer ear—an accumulation of wax, or a blockage caused by swelling and pus—but, more often it is a problem in the middle ear.

In sensory-neural loss, the sound waves reach the inner ear, but are not properly converted into a message that can be passed on to the brain. The sensory-neural loss associated with the aging process is called *"presbycusis."* The person with presbycusis generally hears low-pitched tones, but the high-frequency sounds of speech are distorted. The vowels, such as "a," "e," "i," "o," and "u" are low-pitched sounds; the consonants, such as "th," "s," "sh," "f," and "p" are high-pitched sounds and more difficult to hear. As a result, the person has difficulty discriminating between words that sound similar and consequently has difficulty following a conversation. For example, to a person with presbycusis, fifty and fifteen cents may sound the same. The individual may hear "dead" when you say "bed"; "choose" instead of "juice"; or "fill" for "pill." High-tone loss is universal in old age, but there are marked differences in the degree of loss.

Reactions to hearing loss

Many older people are not aware of the degree of their hearing loss, particularly if the loss has been gradual. Others have difficulty admitting they have a hearing loss, particularly if they equate hearing loss with inadequacy.

Persons with hearing impairments may:

- Speak unusually loudly or softly; their voice may sound monotonous or have an unusual quality.
- Accuse others of mumbling and not speaking clearly.
- Position their head to facilitate hearing.
- Ask a speaker to repeat what has been said.
- Fail to follow directions or to respond to sudden sounds or verbal messages.
- Give inappropriate responses to questions.
- Withdraw from social participation and become increasingly isolated.
- Be distracted easily. Attention span often becomes shorter and the individual usually requires more time to respond to verbal messages and other stimuli.
- Display paranoid behavior, being suspicious of others and what they are saying.

It is important for you to recognize that such behaviors may indicate a hearing loss. Too often, older hard-of-hearing persons who appear confused or give inappropriate responses are labeled as "senile," "stubborn," "dull," "bizarre," and the hearing loss is not diagnosed. The older adult with a hearing loss should be referred to a physician who specializes in hearing problems (otologist/otolaryngologist) and can identify any medical problems and then to an audiologist or speech and hearing clinic for an audiological examination.

Hearing aids

An audiological examination will determine if a hearing aid can help and to what extent. A hearing aid seldom restores normal hearing and it cannot help some hearing losses. Some evidence suggests that older persons are less likely to obtain satisfaction from hearing aids than other age groups.

Although a hearing aid often enhances social participation, many older persons find hearing aids annoying, because not only is the sound of the human voice increased, but *all* sounds are amplified. Sounds may be heard that have not been heard in years.

A period of adjustment is required to learn to use a hearing aid. Sometimes family members and others who work with older adults make a mistake of encouraging older people to wear their hearing aids initially at the wrong times—for example, in noisy situations such as the dinner table when everyone is talking and pots and silverware are clanging. The loudness of so many new sounds may be disturbing and make it difficult to learn to discriminate speech with the hearing aid. Wearing an aid for only a short time (15 to 60 minutes) during a quiet time of the day and gradually increasing the time over a month to 10 to 12 hours a day makes the adjustment easier. It is important to take proper care of a hearing aid to ensure its effectiveness.

The proper fitting of a hearing aid may require several visits to an audiologist for adjustment of the sound range being amplified. Patience and practice will result in a hearing aid becoming a real tool in restoring communication.

What can you do to help?

Communication skills which are often helpful include the following:

- Speak clearly in a moderate voice.
- Do not shout. Shouting creates a booming effect and makes it even more difficult to hear. Shouting only accentuates the vowel sounds and obscures the consonants. This is especially true when speaking to someone with a hearing aid.
- Lower the tone of your voice, particularly if it is high pitched.
- Get the attention of the hard-of-hearing person before speaking.
- Face the hard-of-hearing person directly and on the same level whenever possible. Keep hands

away from face. Many hard-of-hearing rely partially on lipreading to get a message. For the person with both a vision and hearing problem, communication problems are increased.

- Position yourself so that light is shining from above or toward you, rather than from behind into the eyes of the hard-of-hearing.
- Use facial expressions, gestures, and objects to further illustrate the verbal message.
- Speak slowly and distinctly, but do not exaggerate lips. Overarticulation distorts the mouth and what is being said.
- Remove objects from your mouth when speaking, for example, gum, cigarettes, and food.
- Allow longer intervals between sentences. It often takes the older, hearing-impaired person longer to absorb and understand a message.
- Decrease background noises when talking with the hearing-impaired. Turn off the radio and television.
- When giving important instructions to the severely hearing-impaired, write them down as well as give them orally.
- If a person has greater loss in one ear than in the other, direct your conversation toward the "good" ear.
- If a person has difficulty understanding what is being said, use different phrases with similar meaning.
- Try to become aware of acoustical problems in the room or area, and make adjustments to improve speech perception by the hard-of-hearing.
- Keep your voice at about the same volume throughout a sentence.
- Ask the hard-of-hearing person what you can do to help understanding.

When playing music for hard-of-hearing older people, adjust the sound system so lower tones are predominant. Organ music is often popular because of the richness of the lower tones.

Taste

Food that tastes and smells good is important in maintaining a good level of nutrition. However, with increasing age the senses of taste and smell decline and can affect the pleasure and satisfaction older people obtain from food. The number and sensitivity of the taste buds decrease, but these changes usually do not seriously affect taste sensitivity until the seventh decade of life.

Most people over the age of 65 have lost 50 percent of their taste buds. By the late 70's, the average person has one-sixth of the taste buds of a 20-year-old.

Factors other than age, such as smoking and poor mouth and dental hygiene, also affect ability to taste foods.

After the age of 50, the ability to perceive the four taste sensations—sweet, salty, bitter, and sour—decline, but not at the same rate. Studies indicate the taste receptors that identify sweet and salty flavors are the first to atrophy, while those that sense bitter and sour flavors tend to function well into old age.

The older person who has experienced changes in his ability to taste food may reminisce about how much tastier food was when he was young, implying that foods were different and better then. He may quit eating because "nothing tastes good" or he may eat excessively attempting to achieve some taste sensation. A common complaint is that "the food just doesn't taste right," or "this food tastes sour or bitter." As a result, an older adult may put excessive amounts of sugar, salt, or seasoning on his food, which may ruin the flavor of food for a younger person.

Older people who have poor vision and have lost their taste sensitivity often find it difficult to identify foods. Food may have little appeal to them. Diet restrictions, for example bland or low-salt diets, can contribute further to the undesirability of food. Poor health, low physical energy, not wanting to prepare a meal for just one person, and limited budgets also contribute to some older people not eating well.

To encourage eating, food should be prepared and served attractively. Distinctive and varied textures, colors, and temperatures add to the identification and enjoyment of food. Food may need to be more highly spiced. The older person who chews food well and switches from food to food when eating obtains more taste from food, and hence more enjoyment from a meal.

If the person needs assistance with feeding, avoid mixing foods together because such mixing makes it impossible for the individual to separate flavors. Encourage good dental and mouth hygiene.

Smell

Many older people have difficulty identifying common foods and environmental substances by smell. The exact mechanism for this decline is not known; however, studies indicate the sense of smell may be the earliest sensory system to decline with age, beginning as early as the late thirties or early forties.

Because two-thirds of the taste sensations depend on the ability to smell, decline in the smell system may further depress an older person's appetite or interest in food. Loss in the ability to smell may mean an individual can no longer smell body or household odors that may be offensive to others. Warning odors—smoke, gas, or spoiled

foods—may be undetectable. Smoke alarms and pilot lights can decrease the potential hazards that loss of smell creates—especially for persons living alone.

Adding artificial odors to food is one method of improving food flavor for some older persons. For example, artificial green bean odor can be added to green beans and artificial potato odor and flavor added to potatoes. Adding such odors will not be helpful to older adults who have completely lost their sense of smell, but may help some older people enjoy their food more. Artificial odors are manufactured by several companies, including Furmenich, 277 Park Avenue, New York, N.Y. 10017, and International Flavors and Fragrances, 1515 Highway 36, Union Beach, N.J. 07735. The companies may be able to direct you to local distributors or sources. The Extension Service lists these addresses as a service, and does not endorse these products over others that may be available.

Foods with artificial odors added may be aversive to young people or others who do not need them.

Touch

Although research is limited, studies suggest an age-related decline in the sensory system of touch. Skin sensitivity and the ability to detect pain decreases. It becomes more difficult for the person to distinguish textures and objects on the basis of touch alone. A person may not recognize he is being touched or may have a delayed reaction.

Pain threshold increases. As a result, an older adult is more likely to be burned or cut and not know it until severe damage has occurred. The hot temperature of bath water or a heating pad, for example, may not be readily felt. An older person also is less likely to perceive internal body pain or a rising temperature as early as a younger individual. This may result in an illness progressing to an advanced stage before detection. This is particularly common and potentially dangerous in the older diabetic. Because diabetes contributes to loss of nerve sensitivity and blood flow in the feet and legs, severe cuts and bruises may not be noticed and severe infection may result.

For all persons over 70, precautions such as lowering the temperature of a hot water heater help to reduce the likelihood of accidents due to decreased touch and pain sensitivity.

The use of touch can be a powerful therapeutic tool. Yet, evidence suggests that many older adults are touched very little or not at all and suffer from "touch hunger." Touching has a number of advantages. It is a powerful means of communication, it can help make up for loss in other senses, reduce anxiety, and provide comfort. However, when using touch, it is important to consider the older person's background, culture, and sense of private space. A simple handshake or pat on the back can communicate warmth and respect to the older person.

Your Attitude is Important

When working with sensory-impaired older people, keep in mind that personality, life-style, and family and friends affect their adjustment. Many compensate well for their losses. Others may use their loss as a means of getting attention. Those who are proud—and afraid of losing their independence—may refuse help. Your attitude and response toward the old and the handicapped is a key to being an effective helper. Try to avoid distorting a single handicap into a total handicap, and treating the older handicapped individual with a patronizing attitude. Instead, be helpful, while enhancing the elderly person's feelings of adequacy and self-esteem.

This publication was prepared by Vicki L. Schmall, Extension gerontology specialist and assistant professor of family living, School of Home Economics, Oregon State University. It was reviewed and approved for use by the Extension Services of Oregon, Washington, and Idaho.

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What accounts for the sex difference in health and mortality? The answer may provide information about the basic process of aging. Although we know that inherited risks, the trauma of illness and injury, attitudes toward illness, behavior during illness, and changes in the body during aging are important variables, there is a great deal that remains uncertain. Even differences in the willingness of people to report their health problems to researchers may affect our statistics.

Obviously, much research is necessary to learn about health, mortality, and their determinants, especially in persons over 65 who suffer a decline in resistance and an increase in chronic disease. Each new age group, with its own special characteristics, will add new insights. But perhaps most important of all is the understanding of a society aware not only of the special problems of aging but also of the actions necessary to help aging men and women to live more dignified, healthy, and productive lives.

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Prepared by the National Institute on Aging, U.S. Department of Health and Human Services, for the 1981 White House Conference on Aging.

Despite advances in health care and a marked recent decrease in deaths from cardiovascular, cerebrovascular and many other diseases, women continue to outlive men. In this century, death rates for both sexes dropped until about 1950, remained stable until 1970, and then began a sudden and remarkable downward turn. For many years women have benefited more than men from this trend, but there are signs that the gap in life expectancy between men and women may narrow in the future.

Despite the apparent good fortune of women, the added years they live are often lonely ones. Throughout their lives, from infancy on, men run a higher risk of dying than women. Although men tend to fall ill less often than women, they are more likely to be seriously ill; women have more health problems, but generally milder ones.

Sex Differences & AGING

Women thus outnumber men in the group aged 65 and above. In 1979, there were 14.6 million women and 10 million men, or 68 men to 100 women, over 65. With advancing age the ratio becomes more extreme; beyond 85 there are only 45 men per 100 women. By 2050 demographers predict that there will be 33.4 million women and 22.1 million men aged 65 and older. At that time, our population may be almost stationary in size if current birth, death, and immigration rates persist.

In the United States in 1978 life expectancy at birth was 77.2 years for women and 69.5 for men. Current projections are that life expectancy at birth in 2050 will be 81.0 years for females and 71.8 years for males. Some scientists expect, however, that as more women enter the work force—with attendant stress and occupational hazards—their health patterns may become closer to those of men.

Diseases that are common among older people include hypertension, arthritis, diabetes, and cancer; ultimately three fourths of older Americans die of heart disease, cancer, or stroke. Older women have higher rates than older men of most diseases except coronary heart disease. The intensity of the same disease also varies with sex; for instance, although more women tend to have moderate or severe arthritis, men more frequently suffer from mild arthritis. Women tend to have higher rates than men of arthritis, diabetes, anemia, migraine, sciatica, hypertensive heart disease, varicose veins, digestive and urinary problems, allergies, and orthopedic problems, and are more likely to have multiple chronic conditions that not only accumulate but complicate each other.

Men more frequently suffer from such serious health problems as heart disease (especially coronary heart disease), cerebrovascular disease, arteriosclerosis, pneumonia, and emphysema or asthma. They are also more likely to have suffered amputations of extremities. Men also have higher rates of gout, peptic ulcer, hernia, psoriasis and sebaceous gland diseases, and paralysis. Men have more orthopedic problems before age 65; in the group 65 years of age and older, however, women become more vulnerable, principally because of thinning and weakening of bones from osteoporosis. At all ages, women use more therapeutic drugs, including psychotropic ones, than men.

While failing eyesight is a problem for both men and women, older women have more difficulty. Their vision cannot always be corrected even with carefully prescribed eyeglasses. On the other hand, men have poorer hearing and more dental problems.

Older women seem to acknowledge, seek treatment for, and accommodate to health problems better than older men. Although women may have more symptoms and chronic problems, they tend voluntarily to restrict their activities and to take better care of themselves, and thereby prolong their lives. It thus appears that attitude toward illness and behavior during illness are important to the understanding of long-term morbidity and mortality statistics. Studies have shown that people who feel "well" tend to be healthier, more satisfied with life, more involved in social activities, less tense, and less lonely.

Older women tend to suffer more than men from deficiencies of protein, calcium and iron—all of which are important nutrients in the later years. Obesity—another sign of poor nutrition—is also frequent among older women. These problems of nutrition may be related to the fact that more older women than older men live alone.

Long-term care, once synonymous with institutional care, now includes home-care and some types of community-based services. Sometimes the family can help an older person live independently. Above five percent of the U.S. population aged 65 and older live in nursing homes, boarding homes or personal/care facilities; among those aged 85 and older the percentage rises to 10 percent. The majority (71 percent) of nursing home residents are female.

Older men and women need more medical and dental care than younger people. Women tend to visit their doctors more often than men until age 75, when the difference virtually disappears. Hospital admission rates are higher for older men, but women tend to stay longer.

Older people report that they are very satisfied with their medical care. Coverage of medical costs by Medicare and Medicaid, along with the fact that retired persons have more free time to seek help, encourages the use of medical care.

The traditional view that the relationship between older people and their children has deteriorated since the colonial period has been challenged by recent studies of the history of aging.

While it seems true that the elderly of colonial times were treated with great respect, new research tends to the view that they were respected because there were so few of them and because they controlled most of the valuable economic resources, especially land. Indeed, to have lived to old age was itself an accomplishment. Respect, modern researchers conclude, did not necessarily entail affection in a society in which the son often had to wait many years to assume responsibility, or even to marry. Family relations in colonial days may well have been colder and more distant than today.

AGING & the family

Prepared by the National Institute on Aging, U.S. Department of Health and Human Services, for the 1981 White House Conference on Aging

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These studies suggest that the key to warm and constructive relations between generations may lie in mutual independence, both economic and psychological. While today's elderly are not living in a "golden age," their improved finances and health have led to family relations based on cooperation and an exchange of emotional support. Family life thus considered is no longer merely another "social problem," and researchers are finding new perspectives from which to approach the study of intergenerational relations.

Trends that seem to have the most significant effect on an older person's ties with kin include: the number of surviving children, the emergence of the four-generation family, divorce and remarriage, and the increased participation of women in the work force.

Research shows that the greater the number of surviving children the more contact there is between generations. While elderly women who reached childbearing age during the Depression had few children, women whose childbearing years occurred during the 1940s and 1950s had many. Thus, at the turn of the twenty-first century, the chances that an elderly person will have children to lend emotional and material support will increase. From that time, however, because childbearing declined in the 1960s and 1970s, the number of children will decrease.

The emergence of the four-generation family may have both positive and negative consequences for family members. Almost half of those now 65 and over have great grandchildren. In these families, the children of the oldest generation are themselves elderly or nearing old age and may face obligations not only to their children and grandchildren but to their aged parents as well. Both stress and pleasure may result from the multiplication of family demands.

Trends in divorce and remarriage may strengthen intergenerational ties in some ways and weaken them in others. Demographic studies predict that by the turn of the century one-quarter of the elderly will have been divorced. The resultant emotional and financial burden on each family member may in part be alleviated by the addition of new members through remarriage, and the resultant spreading of the burden over a broader base.

Increased participation of women in the labor force may also result in new challenges. Although economic independence may enhance the ties of affection between elderly women and their children, many of the daughters, being employed, will have less time to attend to the needs of their aged parents. The adjustment to retirement may also be difficult for women who have found fulfillment in their careers.

We are in the midst of a period of great change in family relations. Numerous social and population trends will continue to influence relations between generations. The family's major purpose today is to provide psychological rather than economic support. As generations become economically less dependent on one another, family relations may be more important than in the past as a way for the elderly to reaffirm the purpose and meaning of their lives.

GPO 885-296

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Among the fat-soluble vitamins, vitamin D deficiency occurs most frequently. In addition to food sources, this vitamin is produced in the body following exposure of the skin to sunlight. Vitamin D is required for the absorption of calcium, and it is thought that insufficient amounts of these two nutrients may contribute to loss of bone mineral, a disorder especially common among elderly women. In some studies calcium absorption has been shown to decrease with age, particularly after 70. This change correlates best with the blood level of the biologically active form of vitamin D. Dietary vitamin D, as well as that form produced in the skin, must be acted upon by the liver and kidney to produce this biologically active form. Until the processes that control bone mineral content in the elderly are better understood, it is advisable for older people to be certain that their diet is rich in foods that contain large amounts of calcium and vitamin D.

Two other minerals studied were iron and zinc. Decreased iron absorption usually is not the cause of iron deficiency in the elderly. More likely causes are low intake, blood loss, or changes in iron utilization. Blood levels of zinc were significantly low in a group of institutionalized elderly.

Although scientists believe only a small proportion of nutritional problems among the elderly are caused by loss of digestive function with normal aging, there is evidence that the intestine loses some of its ability to adapt to unusual circumstances (e.g. low calcium intake, high fat intake). However, there are many neglected areas of research. Much more information is needed about the effects of aging on the gastrointestinal system, drug-nutrient interactions (including alcohol), and the impact of diseases on digestive function and eating habits.

GPO 885-274

Prepared by the National Institute on Aging, U.S. Department of Health and Human Services, for the 1981 White House Conference on Aging.

Although physicians are concerned about the problem of nutritional deficiencies in the elderly, scientists studying the effect of normal aging on digestion have found only minor changes in the body's ability to digest and absorb nutrients.

More likely causes of nutritional problems are digestive diseases or the use of drugs—both may alter gastrointestinal function. In addition, poor eating habits may be responsible. Poor eating habits can result from age-related changes such as loss of teeth, impaired taste and smell, and decreased salivation, or from loneliness, poverty, disability, mental deterioration, or poor understanding of nutrition.

Whatever the cause, the attempt to prevent or treat deficiencies raises many questions: What diet at each stage of life would best serve to minimize the degenerative changes associated with old age? Can dietary modifications influence the rate of aging? Does malnutrition contribute to premature aging?

AGING & Digestion

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Although there is strong evidence that diet and longevity are related in animals, knowledge of the relation in humans is sparse. Even in chronic diseases associated with aging that often require dietary changes as part of the treatment (for example: atherosclerosis, diabetes, hypertension and osteoporosis), the role of long-term eating habits in the development of the disease remains uncertain.

Before "optimal" diets can be determined, scientists need to know what are adequate amounts for the elderly of the more than 40 nutrients thus far identified as essential in man. In turn, the subtle effects of aging on nutrient digestion, absorption, metabolism, utilization, and excretion must be determined before dietary intakes can be recommended. To date the Recommended Dietary Allowances (RDA's) for adults over 51 have simply been extrapolated from the needs of younger adults.

Since the gastrointestinal tract is the site of nutrient digestion and absorption, one study supported by the National Institute on Aging reviewed the literature to provide a basis for considering this complex issue. The investigators began by looking at studies of food consumption. The studies showed that calcium intake is generally too low in older people, especially in women. Also, many of the elderly consume inadequate amounts of protein, iron, vitamin A, vitamin B complex, and vitamin C. Reported average caloric intakes are significantly below the RDA. However, the high prevalence of obesity among the elderly suggests that the intakes and the RDA are too high for our elderly population. These findings mean that older people should eat more nutrient-rich foods and cut down on "empty calories."

Next, the investigators looked at the literature concerning events in the esophagus, stomach, pancreas, and liver that might affect the utilization of food. Minor functional abnormalities were reported in the esophagus, but symptoms rarely resulted. In the stomach, there were some age-related changes which could result in decreased absorption of iron, vitamin B_{12} and protein. Studies of pancreatic function identified changes in the synthesis and secretion of some pancreatic digestive enzymes, although the clinical significance of these changes is unclear. Studies on the excretion of fat have shown that, with a moderate fat intake, fecal excretion is the same in the elderly as in younger adults. However, when fat intake is higher, or when it is all consumed at the same meal, excretion is higher in the elderly. These results suggest that some decrease occurs in the ability to digest or absorb large amounts of fat.

There have been few studies of intestinal structure in humans, but one such investigation found a reduction in the surface area of the small intestine in elderly people. This is significant because it may mean that nutrients are absorbed less efficiently.

Studies of intestinal function show that protein needs may be higher for older adults. On the basis of his early data one investigator suggests that, until more detailed information is available, the recommendation for the elderly should be one gram of protein per kg. of body weight, in contrast to the .8 gram suggested in the RDA's. Translated to percentages, this would mean that 12% of the daily caloric intake should consist of protein.

Oral glucose tolerance decreases with increasing age, but changes in intestinal glucose absorption are probably not the primary cause. One carbohydrate that may cause problems for the elderly is lactose, a milk sugar. Some people have intestinal discomfort after drinking milk, but in a study comparing a lactose-containing with a lactose-free drink, 70% of the elderly in the study reported no intestinal symptoms after either drink. Thus moderate use of milk—a good source of calcium, protein, and riboflavin—should not cause problems for most older people.

Studies of water-soluble vitamins show that the elderly often are deficient in vitamin B_{12} and folic acid. Although low levels of B_{12} may be due to low production of a substance called "intrinsic factor" in the stomach, many elderly people do not eat enough foods that are rich in these two nutrients. Milk, eggs, and meat are the best sources of vitamin B_{12}, while fresh fruits and vegetables are high in folic acid. Folic acid deficiency is often the cause of anemia in elderly people. Diets low in folic acid are also likely to be low in vitamin C. Low blood levels of vitamin C are often found in the elderly, particularly smokers, those with digestive disease, and those in nursing homes. Low intake is the most likely cause of these low blood levels, at least in the last two groups. Another study suggested that older people need more vitamin B_6.

Until researchers can tell us what is normal age-related memory loss—and what can be done about abnormal changes—here are a few clues to improve your memory:

- Give yourself plenty of uninterrupted time to learn new things. It may take you longer, and you may have to concentrate more, to pick up new information.
- Make sure that the environment is suitable for learning. Lighting should be bright and appropriate eyeglasses or hearing aides should be used. If you are uncertain about the information being presented, don't hesitate to ask someone to speak more clearly or to repeat the information.
- Don't try to do more than you can handle. Processing new information always becomes more difficult if your attention is divided among too many different tasks.
- Don't expect to remember names or facts as fast as you did when you were younger. You'll be able to remember as much as you ever have; it may simply take more time to retrieve information from a much larger storehouse.

GPO 888-269

Prepared by the National Institute on Aging, U.S. Department of Health and Human Services, for the 1981 White House Conference on Aging.

An aging aunt begins to complain that her memory is failing. By all other indications, she is quite healthy—perhaps even "young for her age."

Could it be that a hidden physical problem is affecting her mind? Is she depressed about something you might not be aware of? Do you think that she is acting out her fears and expectations about old age? Is she suddenly trying to use skills or retrieve memories that she hasn't called upon in years? Is she judging herself against the standards set by another generation? Or is her problem, as so many believe, "just old age"?

Each of these theories has been suggested by psychologists and others who are studying the apparent decline in a person's ability to learn and remember with advancing years. None has been proven.

Learning, Memory & AGING

The idea that certain changes in cognition can be expected as part of normal aging is widespread. Persons who study human development have always believed that the functioning of the human mind and body levels off and eventually declines throughout the adult years. Today, the growing number of healthy, active adults surviving into their seventies and beyond challenges this negative view of old age. While young people often outperform older people on laboratory tests of cognitive processes—particularly on tests that measure the basic steps involved in retaining new information rather than those that use previously acquired knowledge—adults' learning and memory performance remains relatively competent in most tests. Moreover, although tests show some decline with age, there are always some older adults who score higher than some younger adults on learning and memory tests. It becomes increasingly clear that age alone cannot be used to predict a person's ability to learn and remember new information.

Many of our false notions of decline result from early studies of aging that compared old people and young people rather than tracing changes in the same people at different ages. Since the passage of time is experienced uniquely by each cohort (people born around the same time), it is impossible to draw conclusions about normal age *changes* by looking at age *differences*. For example, for decades it was believed that intelligence peaks at age 17 and then declines because of aging. This was proven false when studies showed that successive cohorts of young people were simply better prepared than their predecessors to perform well on intelligence tests.

If changes in a person's ability to learn and remember aren't as common as we used to think, what accounts for the changes we see in some aging relatives and friends? Unfortunately, many old people themselves expect to experience memory loss, declining intelligence and mental confusion—so their actions frequently match their expectations.

Changing expectations are only one possible explanation. Scientists who believe that there is a physical cause for memory loss sometimes point to the frequency of sensory losses in the aged. A person suffering from presbycusis (loss of the ability to hear high-frequency sounds, which is common in old age) may not hear telephones ring, may have difficulty hearing human voices, particularly women's, and may have problems in interpreting speech since consonants such as F, S, and Z are difficult to hear. Because the loss is selective, hearing aids may not help. Since the senses are vital to the acquisition of new knowledge, a vision or hearing problem can easily be misinterpreted as a memory problem.

Some scientists suggest that general physical wear and tear, biochemical changes occurring with aging, or poor health may be related to changes in learning and memory. We still know little, however, about the exact nature of the relation between biological and cognitive function.

Depression is often linked to loss of memory and other intellectual functions. This theory deserves greater attention, since depression may be related to loss of near relations, retirement, or failing health—circumstances many older people face, often at the same time.

Finally, there are those who suggest that memory begins to fail because a person stops using the methods, and perhaps tricks, once used to remember information. Unused skills become obsolete.

In studying the way people process new information, researchers find that many of the problems they have discovered along the route of acquiring, storing and retrieving information can be overcome with time, effort and training to use special simple techniques. Consider, for example, how many of us use simple tricks or clues to remember someone's name or some other bit of information. Research shows that if older persons are allowed to study new information in any manner they choose, they are unlikely to use any clues voluntarily. However, when older individuals are trained to organize new information in a certain way, to rehearse it verbally, or to tie the new information to some visual image, their performance on memory tests improves.

Unfortunately, almost all the current studies of learning and memory have taken place in laboratories—where the focus of the research is upon fixed and uncomplicated questions outside the realm of day-to-day experience. It may be that in complex everyday situations, older people have certain advantages over younger people. Learning and memory are both affected by a person's familiarity with the material to be learned and with relevant material. New information is incorporated into an existing framework of knowledge. It is possible, then, that the increasing amount of information in an older person's storehouse of knowledge permits him or her to learn and remember new things despite minor breakdowns in the information-processing system.

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Four basic questions -

1. What educational purpose should be attain?

2. What educational experiences can be provided?

3. How can these experiences be effectively organized?

4. How can we determine whether these purposes are being attained?

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PLANNING

Determine goals and objectives -

Purpose -

Outline -

Introduction - what are we trying to do?

Main Parts - methods
ABE/GED Skills - math, writing, reading, Consumer Ed., citizenship, self-respect, spoken skills.

Review - Does everyone understand?

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Evaluation - Written, oral or both

Conclusion - Did we reach our goals?

Pre Evaluation -

Post Evaluation -

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RESOURCES

Where to Find Them -

What is Needed -

When and Where Available -

Costs -

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MATERIAL LIST

Books, workbooks -

Audio Visuals -

Visuals -

Study Guides -

Handouts -

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Timing -

Questions -

Speed of Presentation -

Knowledge of Audience -

Interest Levels -

Interest Spans -

Subject Matter -

Flexibility -

Pick Plan to Stop -

WORKSHOP HANDOUTS

APPENDIX E

ATTITUDE TOWARD AGING SCALE

Please read all of the following statements, and after each statement, circle:

(A) if you agree with it completely
(B) if you agree with it, but with some reservations
(C) if you disagree with it, but only slightly
(D) if you disagree with the statement strongly

1.	Old people usually don't talk much	A B C D
2.	Old people are adjusting to new conditions all the time, and doing it easily	A B C D
3.	There should be special radio and TV programs for older folks	A B C D
4.	I believe a person is really glad to retire from work when he is 65 or 70	A B C D
5.	I think it is usually a mistake for people over 65 to marry	A B C D
6.	The older you get, the more set in your ways you become	A B C D
7.	Old age can be said to begin around 60 or 63	A B C D
8.	Older people too often like to meddle in other people's business	A B C D
9.	Old people become grouchy and stubborn with the years	A B C D
10.	Physical exercise of some kind is good for you as you grow older	A B C D
11.	Older people need special foods	A B C D
12.	Elderly people prefer to be with people of their own age	A B C D
13.	A person should always try for something better, no matter how old he is	A B C D
14.	As you grow older you must expect to depend upon others	A B C D
15.	Old people can, and are, learning new things all the time	A B C D
16.	Older people cannot expect to lead a completely full or satisfying life	A B C D
17.	As one grows older, one becomes less and less useful	A B C D
18.	People get shorter as they grow older	A B C D
19.	You can't teach an old dog new tricks	A B C D
20.	When I get old, I will still prefer to have some kind of work to do	A B C D

KEEPING MENTALLY ALERT

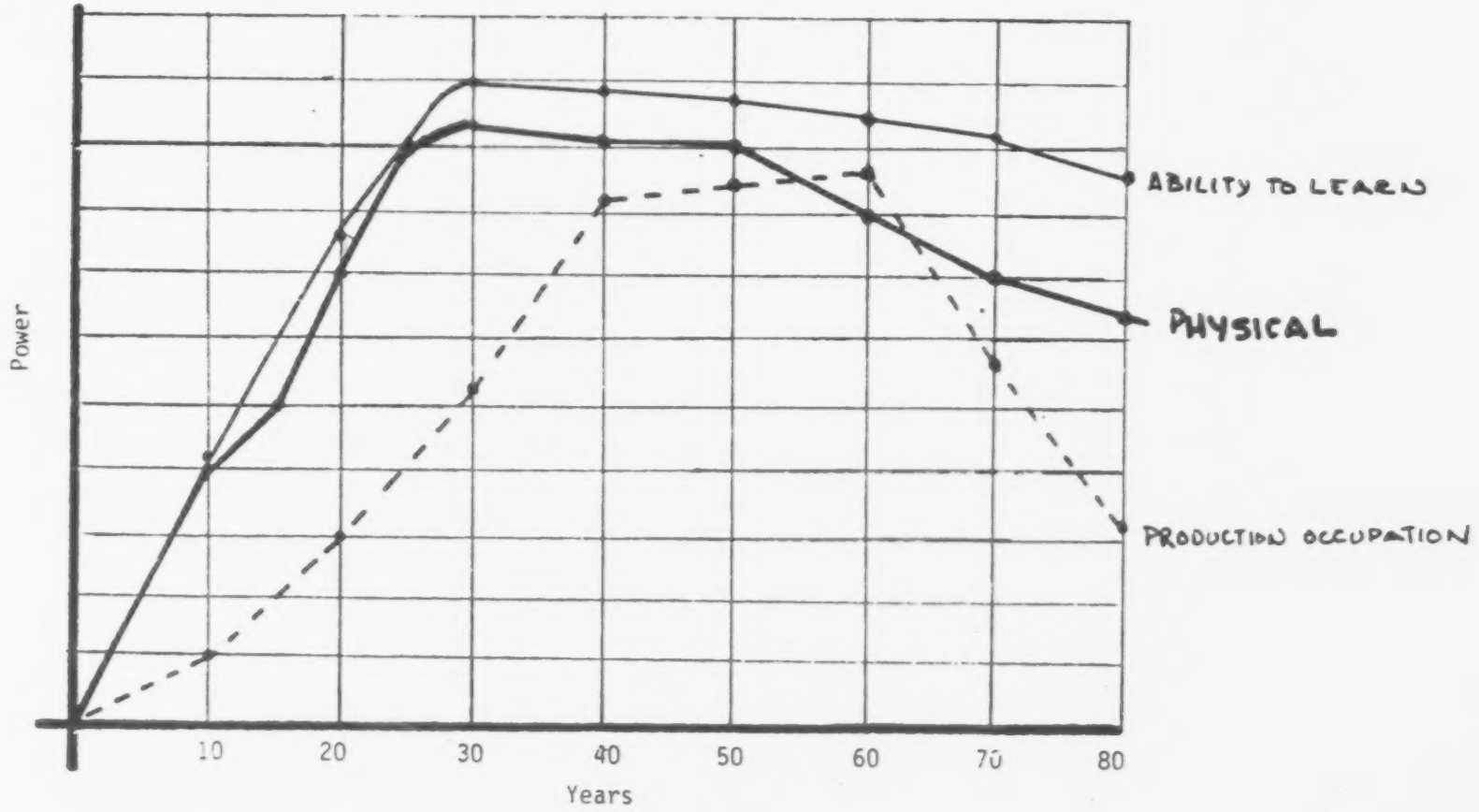
1. Healthy self-concept
   a. Remember real self
   b. Remain as active and independent as reasonably possible
   c. Watch personal thoughts closely
   d. Hang onto sense of humor

2. Improving the memory
   a. Be alert and aware: Concentrate on one thing at a time
   b. Link ideas to images
   c. Cure absentmindedness
   d. Be orderly
   e. Repeat three times
   f. Organize new information
   g. Relax and take your time

3. Maintaining mental capabilities
   a. Stay socially involved
   b. Being mentally active
   c. Having a flexible personality

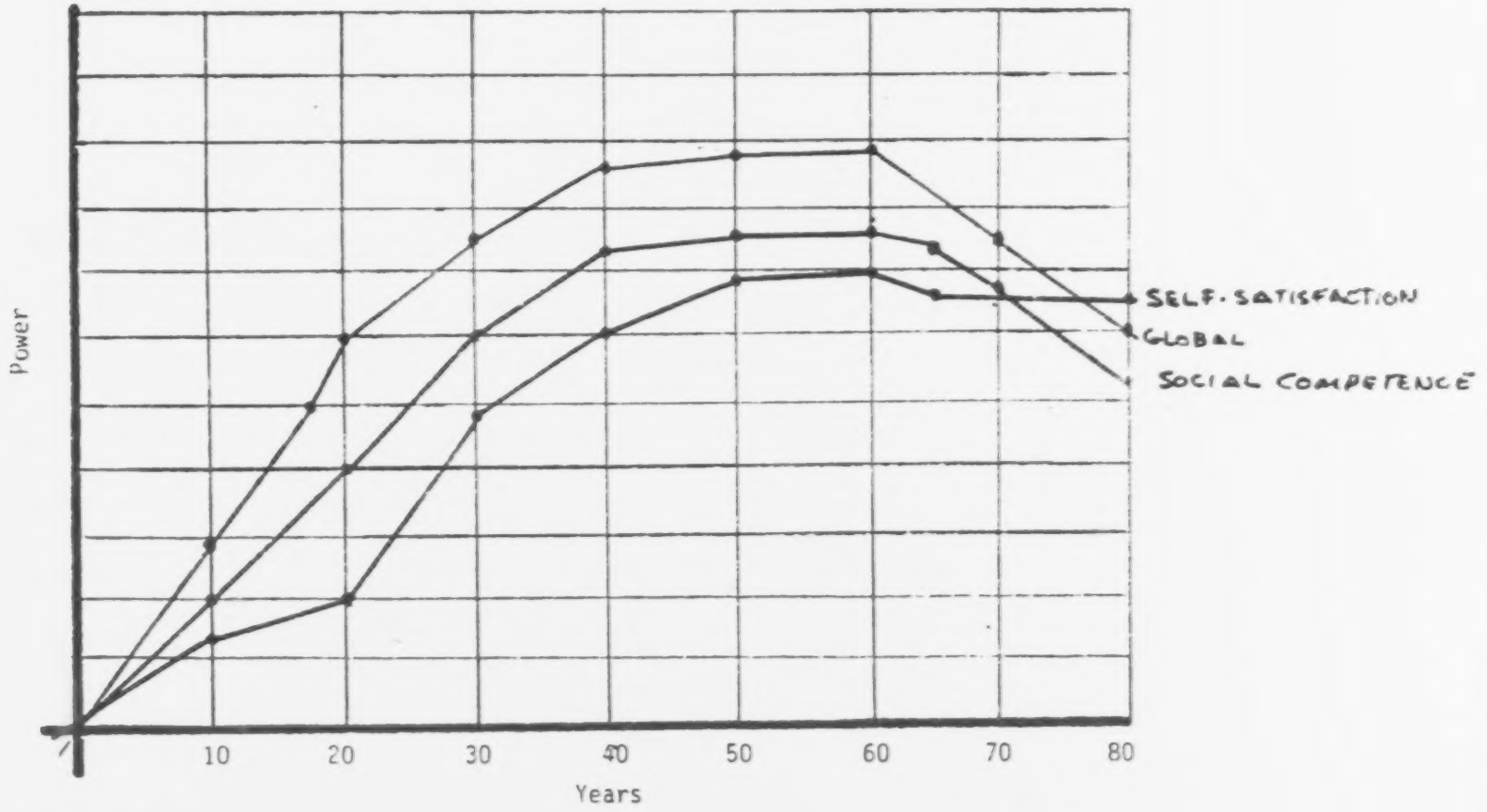
4. Management of hearing loss
   a. Consult doctor, specialist and/or audiologist for most effective treatment

Life Span Curves



Source: Howard McClusky, "Psychology of the Adult," University of Nebraska-Lincoln, 1973.

Life Span Curves



Source: Howard McClusky, "Psychology of the Adult," University of Nebraska-Lincoln, 1973.

SCHEDULE

APPENDIX F

SAMPLE SCHEDULE

APRIL 1985*

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
NOTES	1 Music - C Iowa History-M Wills-L	2 Wills-L Wills-G Music-B	3 Iowa History-M	4 Music - C Wills-G	5 Music-B	6
7	8 Iowa History-C Wills-M Computer-L Computer-G Iowa History-B	9 Computer-L	10 Wills-M	11 Computer-G Iowa History-B	12 Iowa History-C	13
14	15 Wills -C Computer-M Travel-L (Culturgrams) Travel-G	16 Wills-B Travel-L	17 Computer-M	18 Travel-G	19 Wills-C Wills-B	20
21	22 Computer-C Travel-M	23 Computer-B	24 Travel-M	25	26 Computer-C Computer-B	27
28	29 Travel-C**	30 Travel-B**		NOTES		

* There were some classes held in March

** Completed May 3

C - Corning
M - Mt. Ayr
L - Leon
G - Greenfield
B - Bedford

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FLYER

APPENDIX G

SENIOR ADULTS

What Is - Exciting, Fun, Stimulating, & FREE?

Adult Basic Education at Southwestern Community College is offering programs exclusively designed for the Senior Adult! We welcome both men & women to attend these informative four hour programs. They will be held at the Blue Check Room in the State Savings Bank at Bedford.

Bring a friend and enjoy!!!

Clip & Save--------Clip & Save-------Clip & Save-------Clip & Save

SWCC EXCLUSIVE PROGRAMS FOR THE SENIOR ADULT

ALL PROGRAM TIMES ARE FROM 2-4 pm

April

Music From Days Gone By	Tues. & Fri. April 2, 5
Iowa History-The Depression	Mon. & Thurs. April 8, 11
Wills & Trusts	Tues. & Fri. April 16, 19
Becoming Familiar With Computers	Tues. & Fri. April 23, 26
Foreign Travel	Tues. & Fri. April 30, May 3

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ALL PROGRAMS HELD AT THE BLUE CHECK ROOM IN THE STATE SAVINGS BANK AT BEDFORD

RECRUITMENT BREAKOUT

APPENDIX H

RECRUITMENT

Summary of Instructors' Hours Worked

Techniques	#1	#2	#3	#4	#5	TOTAL
Club meetings	1	1.25	2.00		1.00	5.25
Nursing home	2					2.00
One-on-one	3	2.00	.50		3.50	9.00
Congregate Meal Sites	3	.50	1.75	6.00	1.00	12.25
Churches		2.00				2.00
Phone calls					1.25	1.25
Door-to-door	2		2.00	8.00		12.00
In business district (hanging posters & talking to store people)	1					1.00
Arranging & planning advertisements		1.00	8.50	.75		10.25
Library		1.00	.25			1.25
TOTALS	12	7.75	15.00	14.75	6.75	56.25

RECRUITMENT

Summary of Instructors' Hours Worked

Techniques	#1	#2	#3	#4	#5	TOTAL
Club meetings	1	1.25	2.00		1.00	5.25
Nursing home	2					2.00
One-on-one	3	2.00	.50		3.50	9.00
Congregate Meal Sites	3	.50	1.75	6.00	1.00	12.25
Churches		2.00				2.00
Phone calls					1.25	1.25
Door-to-door	2		2.00	8.00		12.00
In business district (hanging posters & talking to store people)	1					1.00
Arranging & planning advertisements		1.00	8.50	.75		10.25
Library		1.00	.25			1.25
TOTALS	12	7.75	15.00	14.75	6.75	56.25

SAMPLES OF PUBLICITY

APPENDIX I

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SAMPLES OF PUBLICITY

CLIP AND SAVE

Adult Basic Education of SWCC
Presents
FREE Exclusive Programs
for the Senior Adult

APRIL:
Music from Days Gone By
Tues., April 10 thru Fri., April 13 at 2 p.m.
Exercise for the Senior Adult
Tues., April 24 at 2 p.m.

MAY:
Becoming Familiar with Computers.
Tues., May 8 thru Fri., May 11 at 7 p.m.
Cooking for 1 or 2
Tues., May 22 at 7 p.m.

JUNE:
Foreign Travel
Mon., June 18 thru Thurs., June 21 at 7 p.m.

All programs held at Regency Park's Activity Center in Creston. Need Transportation? Call the area agency for S.W. Iowa Trolley Service - 782-4040.

CLIP AND SAVE

CLIP AND SAVE

CLIP AND SAVE

TIME FOR A SPRING TUNE-UP?

Bring a friend, Come and enjoy.
Southwestern Community College's
FREE MINI COURSES - SENIOR ADULTS

March 18 and 19 - Music from Days Gone By
March 25 and 26 - Iowa History - The Depression Days
April 1 and 2 - Understanding Wills and Trusts
April 8 and 9 - Becoming Familiar with Computers
April 15 and 16 - Foreign Travel

All programs held at the Leon Community Center from 1:30 p.m. - 3:30 p.m. on the above dates.

Contact Margaret Moore for further information.

CLIP AND SAVE

Local classes cater to senior citizens

Southwestern Community College is offering several free programs designed specifically for senior citizens. These one-hour programs will be presented at the Regency Park Activity Center.

The topic for April is "Music From Days Gone By" and will be over four days, covering folk music, spirituals, etc. It will be entertaining and enlightening to anyone interested in music from folk songs, spirituals and songs of the South, work songs and war songs to popular love songs. The dates are Tues., April 10, through Fri., April 13, from 2 to 3 p.m. each day.

The other program scheduled for April is "Exercise For The Senior Adult" on Tues., April 24, 2-3 p.m. It will give several simple exercises and lots of encouragement to start and maintain an exercise routine at home.

Other programs scheduled are "Becoming Familia... Computers" Tues., May 8, throu... May 11, 7-8 p.m.; "Cooking F... or Two" on Tues., May 22, 7 ...nd "Foreign Travel," Mon., ...ugh Thurs., June 21, 7-8 p.m.

Anyone wh... ...ike transportation may ...west Iowa Trolley, 782-40...

SWCC program for senior adults

Southwestern Community College is offering several free programs in Mount Ayr designated for senior adults.

Each of these programs consists of two two-hour classes which will be presented at the Heritage Park Community Room in Mount Ayr. The programs are designed to be informative and fun and will cover a variety of topics.

The topic for March will be "Music From Days Gone By" which will cover folk songs, spirituals, songs of the South, work and war songs and popular love songs. The dates for this are Monday, March 25 and Wednesday, March 27 from 4-6 p.m.

* *

CLASSES FOR SENIOR CITIZENS
Sponsored by SWCC, held at Regency ...k in Creston:
+April 10, 11, 12, 13, 2:00-3:00 p.m. "Music From Days Gone By"
+April 24, 2:00-3:00 p.m. "Exercise for Senior Adults"
+May 8, 9, 10, 11, 7:00-8:00 p.m. "Becoming Familiar With Computers"
For more information call SWCC, 782-7081, Barb Stephens. For transportation in Creston, call the Southern Iowa Trolley.

Extension Ltr.

* * * * * * * * * * * * 85 * * * * * * * * *

PRE-ASSESSMENT/POST-ASSESSMENTS

APPENDIX J

"GETTING TO KNOW YOU"

MUSIC FROM DAYS GONE BY

NAME

ADDRESS

BIRTHDATE

DID YOU PARTICIPATE IN CHORUS IN SCHOOL?

YES - 51
NO - 13

HAVE YOU EVER SUNG IN A CHURCH CHOIR?

YES - 56
NO - 10

DO YOU PLAY AN INSTRUMENT? IF YES, WHAT INSTRUMENT?

Oboe - 1	Sax - 2	Trumpet - 2	Cymbals - 1
Piano - 31	Violin - 2	Trombone - 1	Drums - 2
Mouth harp - 1	Accordion - 1	Tamborine - 2	Banjo - 1
Guitar - 5	Organ - 5	Triangle - 1	Morocci - 1

WHAT KINDS OF MUSIC DO YOU ENJOY THE MOST?

Band - 2	Popular - 8	Orchestra - 1	Organ - 1
Gospel - 36	Classical - 10	All kinds - 7	
Old time - 29	Folk - 21	Jazz - 2	
Country - 29	Ballads - 1	Symphony - 2	

WHY DID YOU ENROLL IN "MUSIC FROM DAYS GONE BY"?

Enjoy music

LEARNED ABOUT THIS PROGRAM:

Flyer - 16	Radio - 28
Newspaper - 26	Other - 17
TV - 6	Shopper - 2

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MUSIC FROM DAYS
GONE BY - RED OAK

AFTER THE BALL"

DID YOU ENJOY "MUSIC FROM DAYS GONE BY"?

WHY OR WHY NOT?

YES - 57
NO - 1 (not musical)

WHICH DID YOU ENJOY MOST? (CHECK ONE)

37 LISTENING
9 DANCES
60 SINGING
8 GAMES & ACTIVITIES

WHICH SECTION OF THE UNIT WAS BEST FOR YOU? (CHECK ONE)

19 FOLK MUSIC
20 SPIRITUALS AND SOUTHERN SONGS
9 WORK SONGS AND WAR SONGS
71 THE OLD POPULAR SONGS

IF ANOTHER DAY OF THE WEEK IS BETTER FOR YOU, CHECK ONE.

15 MONDAY
10 FRIDAY
6 TUESDAY
1 SATURDAY
13 WEDNESDAY
3 SUNDAY
12 THURSDAY

WAS THE CLASS 3 TOO LONG? 13 TOO SHORT? 61 JUST RIGHT?

WHAT WOULD YOU CHANGE TO MAKE THE PROGRAM BETTER?

Sing by participation and notes - 2
leader who can carry a tune - 3
lower music - 4
use instruments - 2
Advertise more - 3

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NAME _____

PRE ASSEMENT SURVEY

1. Have you ever traveled in a foreign country?

yes 8 no 27

2. If so, where have you traveled?

Mexico - 3
Canada - 5
Europe - 2

3. How did you go?

on your own 6
with a tour group 2
with a few other people 4

4. Have you ever contacted a travel agent to help you plan any trip?

yes 9 no 17

5. What countries or regions would you like to visit?

Florida - 1; France - 1; Maine - 1; England - 2; Sweden - 4;
Alaska - 1; Germany - 1; Hawaii - 5; U. S. - 5; Switzerland - 2;
California - 1

6. Check the following areas you would like to learn more about.

4	Passports	3	Money
2	Time Changes	2	International Calling
1	Jet Lag	4	Letter Writing
5	Packing	7	Airports & Airlines
2	Insurances	2	International Signs
8	Getting over the language barrier		

7. How did you find out about this program?

	radio	13	friend
5	brochure	7	other Meal site

WHAT DO YOU THINK?

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1. Check the parts of the program that you enjoyed most.

___ Study of world map (continents, equator, etc.)

6 Passports

3 Time zones

1 Jet lag

1 Packing

4 Money games

8 Phone calling

2 Letter writing

8 Airports & airlines

___ Insurances

7 International signs

___ Language lessons

5 Travel agent presentation

3 Going through a tour book

4 Movies

2. As a result of this class, do you feel more confident about your ability to travel abroad? Why or why not?

YES - 6

3. Do you think you will ever travel to a foreign country? Why or why not?

NO; No Money - 5
NO; Too Old & poor health - 3
NO; 2
YES; 2

GETTING TO KNOW YOU

NAME:

ADDRESS:

BIRTHDATE:

WHAT DO YOU REMEMBER MOST ABOUT THE DEPRESSION?

Dust storms - 7
Cinch bugs - 3
Low food supply - 8
Dried-up crops - 9
Heat - 5
Canned what food they had - 5
Banks closing - 7
No jobs - 7
No money (low wages) - 22
Friends & family stuck together - 4
Lack of water - 2
Inconveniences - 9

HOW DID YOU HEAR ABOUT THIS PROGRAM?

1 RADIO	1 CABLE TV	23 FRIEND
8 NEWSPAPER	14 FLYER	12 OTHER

Iowa-Depression Years Evaluation

1. Did you enjoy "Iowa-Depression Years"?

   Why or why not?

   YES - 21

   Reminising; families worked together - 1
   learned values - 1
   new information - 5

2. What did you enjoy most?

   22 Listening

   6 Reading

   19 Reminising and Discussion

   Did not com Filmstrip

3. Which lesson was best for you?

   6 Day 1

   1 Day 3

   5 Day 2

   5 Day 4

   ENJOYED ALL OF THEM 7

4. Was class

   4 (1 hr enough) too long?

   1 too short?

   18 just right?

5. What would you change to make the program better?

   Wish it had been taped
   Get more awareness of the class to the community
   More films maybe

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RED OAK COMPUTER

NAME_____

PLEASE RATE THE CLASS FROM 1-5, WITH 1 LOWEST AND 5 HIGHEST

	NO.....				YES
1. I LEARNED MANY NEW THINGS IN THE CLASS.	1	2	2 3	4	9 5
2. COMPUTERS SCARE ME LESS SINCE THE CLASS.	5 1	2	4 3	2 4	5 5
3. THE TEACHER EXPLAINED THE TERMS WELL.	1	2	3	4 4	12 5
4. I WASTED MY TIME BY COMING TO CLASS.	12 1	2 2	1 3	4	2 5
5. I FEEL I CAN TALK TO MY CHILDREN OR GRAND-CHILDREN ABOUT COMPUTERS NOW SINCE THE CLASS.	3 1	4 2	3 3	1 4	5 5
6. I MIGHT TAKE ANOTHER CLASS ON COMPUTERS.	3 1	1 2	2 3	2 4	8 5
7. I AM INTERESTED IN OTHER ADULT EDUCATION CLASSES.	2 1	1 2	3	4	13 5
8. MY NEIGHBORS TALKED ME INTO COMING TO CLASS.	14 1	2 2	3	4	1 5
9. I LIKED THE CROSSWORD AND WORD SEARCH.	1	1 2	2 3	1 4	13 5
10. COMING TO CLASS IMPROVED MY READING SKILLS	8 1	1 2	3 3	4	2 5
MATH SKILLS	8 1	2 2	2 3	4	1 5
LANGUAGE SKILLS	9 1	2	3 3	4	1 5

ARE THERE OTHER CLASSES IN ADULT EDUCATION YOU WOULD LIKE TO HAVE TAUGHT?

YES - 6 NO - 1
Classes for widows - 1
Investments - 1

HAS YOUR ATTITUDE CHANGED ABOUT COMPUTERS BY COMING TO CLASS? HOW?

No - 2
Yes - 7

LEARNED ABOUT THE PROGRAM - flyers, Extension letter, newspaper

DISSEMINATION WORKSHOP AGENDA AND EVALUATION

APPENDIX K

Southwestern Community College

1501 WEST TOWNLINE STREET - CRESTON, IOWA 50801

OFFICE OF THE DEAN OF ADULT AND CONTINUING EDUCATION
(515) 782-7081

TO: Adult Basic Education Coordinators

FROM: Barb Stephens, ABE/GED Coordinator

DATE: April 22, 1985

SUBJECT: May 15 "Senior Adults on the Go" Project Dissemination Telenetwork

The two-year 310 project is coming to a close; therefore, it's time to share Southwestern's findings.

The purpose of the project was to design, develop, and implement educational activities for rural senior adults emphasizing recruitment of the "non-captive" target group.

The agenda for the videotape/telenetwork session is enclosed. The session is scheduled for May 15 from 9 am - 12 pm. I invite you and any of your ABE instructors to participate in the project dissemination. Both mileage and meal cost for instructors will be covered by the project.

Five four-hour units for senior adults have been developed by SWCC ABE instructors. Each participant will receive handouts and copies of the units. Each area school will receive a set of materials to be used with each unit. The unit topics are Introduction to Computers; Iowa History-The Depression Years; Music From Days Gone By; Foreign Travel; and Understanding Wills, Trusts and Estates.

Each telenet site will need to have a 1/2" videotape playback unit. The tape has been taped at regular speed. It is a two hour tape. The majority of the program will be taped; however, the telenet will be used for discussion, introductions, and conclusion. I'm hoping the videotape will add a more personal touch. Each coordinator knows how "cold" telenet can be. I am asking each coordinator to make local arrangements for the playback unit. The telenet session has been scheduled with Pam.

SENIOR ADULTS ON THE GO

A Dissemination Inservice for the 310 Project
Developed by
The Adult Basic Education Program*
At Southwestern Community College

AGENDA

9:00 - 9: 15	TELENETWORK	Attendance, Introductions, Procedures
9:15 - Noon	VIDEOTAPE	Introduction and Background of Project Operation of Project
		Characteristics of Senior Adults Methods of Instruction Unit Writing
	TELENETWORK	Discussion
		BREAK
	VIDEOTAPE	Units and Support Materials
		Recruitment Procedures Instructor's Comments
	TELENETWORK	Discussion
		Conclusion

*Workshop presenters - Barb Stephens, Jane Jacobus, Miriam Brown, and Margaret Moore.

Senior Adults On The Go
Videotape/Telenet Dissemination Presentation Evaluation
May 15, 1985

Please complete and return to Barb Stephens, SWCC, by May 24.

1. The pre-workshop information was?

____ poor 5 adequate 13 good

Comments: Earlier dissemination would be helpful

2. The presentation was? 2 boring 21 informative

The handouts were? 18 adequate ____ inadequate

Comments: Have already had requests from ABE instructors for handouts; lectures were tedious at times; evaluation comments cut & dried with no medium in comment; concept excellent; have variety

3. How effective was the videotape/telenet combination?

18 It made it more personal and added another dimension.
____ It was a waste.

Comments: Video transmission lost between Jane's presentation; presentation well organized; good idea

4. Please estimate time and dollars saved through use of the telenet rather than a face-to-face meeting.

4 to 10 hr time $36 - $100 dollars

Do you derive benefit in the peer communication or networking the system makes possible. 14 yes ____ no

Comments: Not much "communication" on telenet - very limited. Face-to-face best, but telenet better than printed material.

5. Rate the effectiveness of the presenters.

Barb Stephens	Poor		Adequate	1	Good	17	Excellent 1
Jane Jacobus (Hard to understand)	Poor		Adequate	3	Good	16	
Miriam Brown	Poor		Adequate	3	Good	15	
Margaret Moore	Poor	4	Adequate	5	Good	10	

Comments: Very innovative

6. Will the material presented be useful to you? 14 yes ___ no

Handouts will be beneficial. Would like to have instructors teach older adults in the community. Need to become aware of what is being done in the area.

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Comments:

7. List additional comments or specific requests.

A. Good organization, scope and presentation
B. Good idea for an ABE retreat activity; training in video-taping
C. Could not hear Margaret on the video tape
D. Visual aids could have been used more
E. Use video tape to teach other teachers
F. Tape actual class of senior citizens
G. Would have liked to hear more discussion
H. As additional units are completed, please share

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